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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10655

## 10655 CERTIFICATE OF DEATH

Reg. Dist. No. 80

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>New Windsor</u>		<u>years</u>		TOWN <u>New Windsor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Church St.</u>				STREET ADDRESS (If rural give location) <u>Church St.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>MARY</u> (Middle) <u>ELLEN</u> (Last) <u>ALEXANDER</u>				(Month) <u>Nov.</u> (Day) <u>28</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>married</u>	<u>3/26/1908</u>	<u>47</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housekeeper</u>		<u>at home</u>		<u>Maryland</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William H. Green</u>				<u>Anna Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>no</u>		<u>214-28-0184</u> <u>Talbot A. Alexander, New Windsor, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
153X IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma 7 Colon</u>						<u>3 1/2 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>Feb. 1953</u>		<u>Carcinoma Colon</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26</u> , 19 <u>53</u> , to <u>Nov 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>55</u> , and that death occurred at <u>11:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James J. March</u>				ADDRESS (Street, city, town, state) <u>M.D. Westminster Md.</u>		DATE SIGNED <u>11/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/1/55</u>		<u>Pipe Creek Cemetery</u>		<u>Carroll County, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 20, 55</u>		<u>Carroll J. March</u>		<u>D. D. Hartzler &amp; Sons, New Windsor, Maryland</u>			

# 1925 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

For Use by

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Place of Birth

6. Date of Death

7. Time of Death

8. Cause of Death

9. Place of Death

10. Name of Physician

11. Name of Undertaker

12. Name of Burial Place

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10656 CERTIFICATE OF DEATH

10660

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Sykesville, Maryland</u>		<u>3yrs. 8mos.</u>		TOWN <u>Dickeyville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2301 Tubker Avenue</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Lavinia</u>		(Middle) <u>Martha</u>		(Last) <u>Anderson</u>			
(Type or Print)							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Sept. 29, 1872</u>	
						9. AGE last birthday <u>83</u> yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laundress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Laundress</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas James Stauffer</u>				14. MOTHER'S MAIDEN NAME <u>Annie Browner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>7-14-55</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>430.1 Coronary occlusion</u>				<u>15 mins.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Chronic myocarditis</u>				<u>5 yrs.</u>			
Generalized arteriosclerosis							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-14-</u> , 19 <u>53</u> , to <u>11-14-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-13-</u> , 19 <u>55</u> , and that death occurred at <u>4:19</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>M. D. Martin M.D.</u>				DATE SIGNED <u>11-14-55</u>			
ADDRESS (Street, city, town, state) <u>Springfield Hospital, Sykesville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-16-55</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Green</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>G. Howard Strong</u>		ADDRESS <u>North Yellow Bluffs</u>	
DATE <u>Nov. 14, 1955</u>							

# CERTIFICATE OF DEATH

10000

Reg. Dist. No. 1

1. NAME OF DECEASED

John J. Smith

2. SEX

Male

3. AGE

45

4. DATE OF DEATH

10-15-1955

5. TIME OF DEATH

10:30 AM

6. PLACE OF DEATH

Home

7. CAUSE OF DEATH

Heart Disease

8. MANNER OF DEATH

Natural

9. SIGNATURE OF PHYSICIAN

John J. Smith

10. SIGNATURE OF REGISTRAR

John J. Smith

11. SIGNATURE OF WITNESSES

John J. Smith

12. SIGNATURE OF DECEASED

John J. Smith

13. SIGNATURE OF BURIAL OFFICIAL

John J. Smith

14. SIGNATURE OF INTERVIEWER

John J. Smith

15. SIGNATURE OF DECEASED

John J. Smith

16. SIGNATURE OF DECEASED

John J. Smith

17. SIGNATURE OF DECEASED

John J. Smith

18. SIGNATURE OF DECEASED

John J. Smith

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RECEIVED

MASSACHUSETTS

DEPARTMENT OF HEALTH-CAMBRIDGE

10657  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. 10661  
No. 74

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Sykesville</u>		<u>Minutes *</u>		TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR was boarding in Foster Care on				STREET ADDRESS (If rural, give location)			
<u>Spout Hill, Sykesville - Patient</u>				<u>527 East Clement Street</u>			
STREET ADDRESS <u>Parole status since 3/11/48; she</u>							
<b>3. NAME OF DECEASED:</b> (Type or Print) <u>MARY ANN BACHMAN</u>				<b>4. DATE OF DEATH</b> <u>11/27/55</u>			
<b>5. SEX:</b> <u>Female</u>		<b>6. COLOR OR RACE:</b> <u>W</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Divorced</u>		<b>8. DATE OF BIRTH:</b> <u>12/21/08</u>	
<b>9. AGE last birthday:</b> <u>46</u> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>none</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY:</b>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>Baltimore</u>	
<b>13. FATHER'S NAME:</b> <u>William Bosley</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Daisy Cole</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY No.:</b>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Record, Springfield State Hospital</u>	

<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>					
<u>023X</u> <b>Immediate cause</b> (a) <u>Acute myocardial infarction</u>				<u>instant</u>	
<b>DUE TO</b>					
<b>Antecedent cause(s)</b> (b) <u>syphilitic aortitis of coronary orifices</u>				<u>years</u>	
<b>DISEASES OR CONDITIONS, if any, giving rise to the above cause stating underlying cause last</b> (c)					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic brain syndrome associated with syphilitic meningo-encephalitis with psychosis since 1945</u>				<u>known</u>	
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>		<b>20. AUTOPSY?</b> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town) (County) (State)</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
<b>SIGNATURE</b> <u>James J. Tharrah</u>		<b>CHIEF MEDICAL EXAMINER</b> <b>DEPUTY MEDICAL EXAMINER</b> <b>ASSISTANT MEDICAL EXAM.</b> M. D. <u>11/27/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Dec. 1, 55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park</u>	
<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore, Md.</u>		<b>24. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <u>JOHN F. DENNY, INC. 715 Light St.</u>			
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>			

MINISTRE DES TRAVAUX PUBLICS  
DEPARTMENT OF PUBLIC WORKS

REPORT AND STATEMENT OF DEATH - CANADIAN

1. Name of deceased		2. Age		3. Sex		4. Date of death	
5. Place of death		6. Cause of death		7. Nature of disease		8. Name of physician	
9. Name of informant		10. Address of informant		11. Signature of informant		12. Signature of physician	
13. Name of funeral home		14. Address of funeral home		15. Signature of funeral home		16. Signature of registrar	
17. Name of registrar		18. Address of registrar		19. Signature of registrar		20. Signature of coroner	
21. Name of coroner		22. Address of coroner		23. Signature of coroner		24. Signature of judge	
25. Name of judge		26. Address of judge		27. Signature of judge		28. Signature of jury	
29. Name of jury		30. Address of jury		31. Signature of jury		32. Signature of witness	
33. Name of witness		34. Address of witness		35. Signature of witness		36. Signature of doctor	
37. Name of doctor		38. Address of doctor		39. Signature of doctor		40. Signature of nurse	
41. Name of nurse		42. Address of nurse		43. Signature of nurse		44. Signature of pharmacist	
45. Name of pharmacist		46. Address of pharmacist		47. Signature of pharmacist		48. Signature of undertaker	
49. Name of undertaker		50. Address of undertaker		51. Signature of undertaker		52. Signature of cemetery	
53. Name of cemetery		54. Address of cemetery		55. Signature of cemetery		56. Signature of registrar	
57. Name of registrar		58. Address of registrar		59. Signature of registrar		60. Signature of coroner	
61. Name of coroner		62. Address of coroner		63. Signature of coroner		64. Signature of judge	
65. Name of judge		66. Address of judge		67. Signature of judge		68. Signature of jury	
69. Name of jury		70. Address of jury		71. Signature of jury		72. Signature of witness	
73. Name of witness		74. Address of witness		75. Signature of witness		76. Signature of doctor	
77. Name of doctor		78. Address of doctor		79. Signature of doctor		80. Signature of nurse	
81. Name of nurse		82. Address of nurse		83. Signature of nurse		84. Signature of pharmacist	
85. Name of pharmacist		86. Address of pharmacist		87. Signature of pharmacist		88. Signature of undertaker	
89. Name of undertaker		90. Address of undertaker		91. Signature of undertaker		92. Signature of cemetery	
93. Name of cemetery		94. Address of cemetery		95. Signature of cemetery		96. Signature of registrar	
97. Name of registrar		98. Address of registrar		99. Signature of registrar		100. Signature of coroner	

STATISTICAL SECTION



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10658

## CERTIFICATE OF DEATH

10662

74

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>9 month 1 day</u>		TOWN <u>Baltimore (24)</u>		<u>3401.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3104 O'Donnell Street</u> ✓			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>SARAH ELIA BEALL</u>				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>18</u> (Year) <u>19 55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>5-27-69</u>	9. AGE last birthday <u>86</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Samuel Ryan</u>				14. MOTHER'S MAIDEN NAME <u>Mary Priscilla Turner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Tuberculosis of lung - far advanced</u>						<u>Unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</u>						<u>10 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>2-17</u> , 19 <u>55</u> , to <u>11-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-17</u> , 19 <u>55</u> , and that death occurred at <u>3:00A.M.</u> from the causes and on the date stated above. <b>SIGNATURE</b> <u>Walther H. Sonnenfeld</u> M.D. <b>ADDRESS</b> (Street, city, town, state) <u>M.D. Springfield State Hosp. - Sykesville</u> <b>DATE SIGNED</b> <u>11-18</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/22/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 22 1955</u> DATE		REGISTRAR'S SIGNATURE <u>C. J. ...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Moran</u> ADDRESS <u>3000 E. Balto. St.</u>			

# STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 10 CERTIFICATE OF DEATH

REG. NO. 1000

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

SIGNATURE OF PHYSICIAN

SIGNATURE OF REGISTRAR

SIGNATURE OF WITNESS

SIGNATURE OF DECEASED

SIGNATURE OF NEXT OF KIN

SIGNATURE OF CLERGYMAN

SIGNATURE OF BURIAL

SIGNATURE OF CREMATION

SIGNATURE OF OTHER

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BUREAU V. S.

NOV 28 1935

RECEIVED

John A. Mosen 3000 E. Balto. St.  
Baltimore, Md.

11/21/35 Baltimore, Md.

Bureau



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**1** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10663

10659 **CERTIFICATE OF DEATH**Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>rural Westminster</u>		<u>37 days</u>		TOWN <u>rural Westminster</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R 4 Mexico</u>				STREET ADDRESS (If rural give location) <u>R 4 Mexico</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Joan Marie Blum</u>				<u>Nov. 17 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months	<b>IF UNDER 24 HRS.</b> Days	<b>Hours</b> <b>Min.</b>
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>October 7, 1955</u>	<u>--</u>	<u>1</u>	<u>16</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>child</u>		<u>at home</u>		<u>Md. Gen. Hospital Balto.</u>		<u>USA</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Raymond C. Blum</u>				<u>Kathleen Null</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>-----</u>		<u>Raymond C. Blum R4 Westminster, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>480X</u>				<u>Broncho-Pneumonia</u>		<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)				<u>Influenza</u>		<u>4 days</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>11/16</u>, 19<u>55</u>, to <u>11/17</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/17</u>, 19<u>55</u>, and that death occurred at <u>3:30</u> P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>			
<u>Heather Rose</u>		<u>Westminster Maryland</u>		<u>11/18/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Nov. 18, 1955</u>		<u>Luthern Cemetery</u>		<u>Taneytown, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>11-19-55</u>		<u>Hannet Miller</u>		<u>John R. Byers</u>		<u>Westminster, Md.</u>	

2055274405



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10664

10660 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Carroll Co.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tyrone</u> LENGTH OF STAY (in this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Tyrone</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tyrone Rd.</u>		STREET ADDRESS (If rural, give location) <u>Tyrone Rd.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY CECILIA BOND</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 12 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 1, 1891</u>
9. AGE last birthday <u>64</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gerald P. Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Ann M. Greager</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>220-22-1622</u>	
17. INFORMANT AND ADDRESS <u>Miss Ann Doyle - 1135 Orem Rd. 20</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>151X Carcinoma, Stomach</u>		
(b) Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c) II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1955, to Nov. 11, 1955, that I last saw the deceased alive on Nov. 11, 1955, and that death occurred at 6 A. m., from the causes and on the date stated above.

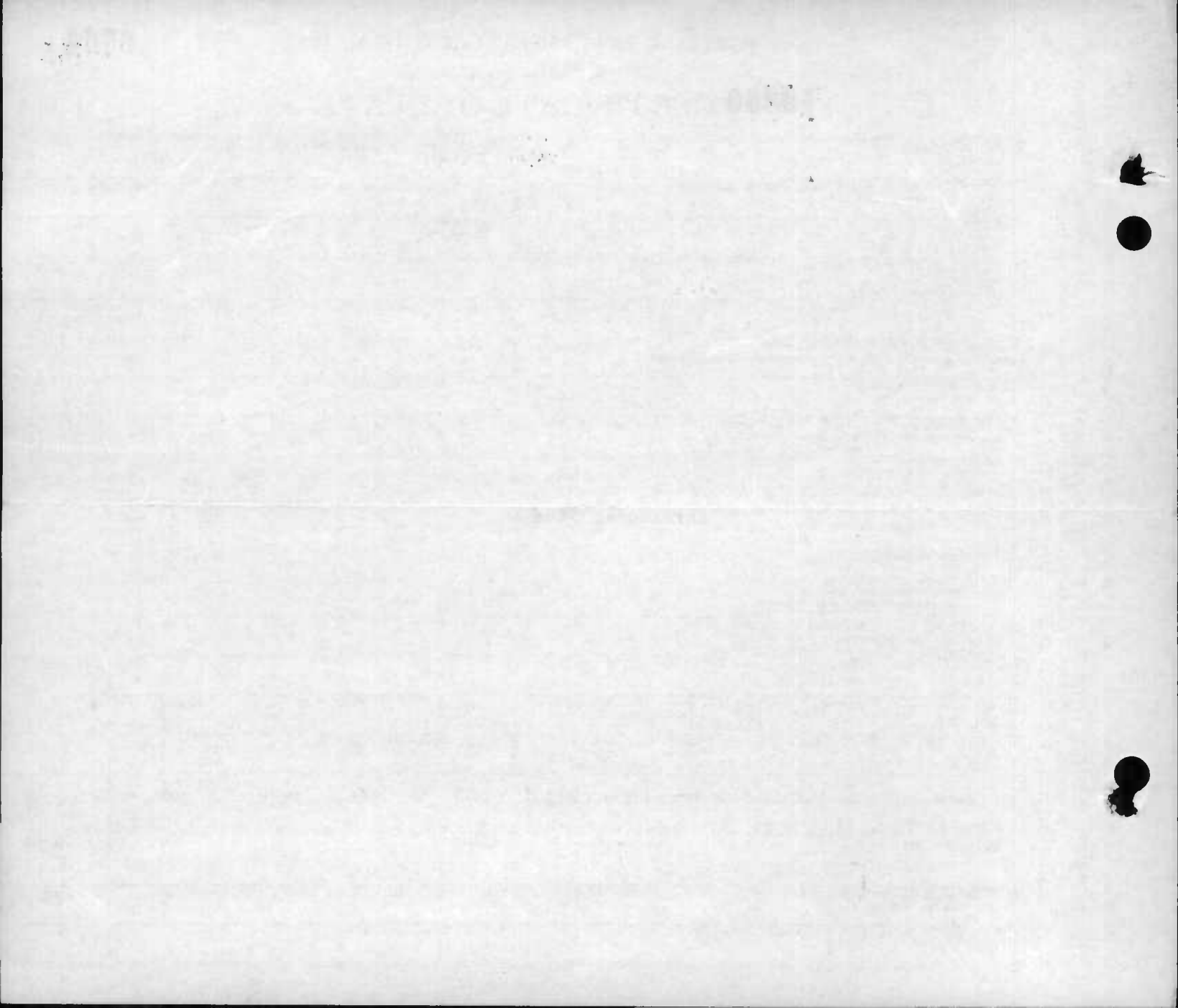
SIGNATURE J. N. Legg (Degree or title) ADDRESS Union Bridge, Md DATE SIGNED 11-12-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>Nov. 13, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) <u>Balto.</u> (State) <u>md.</u>
DATE REC'D BY LOCAL REG. <u>11/14/55</u>	REGISTRAR'S SIGNATURE <u>H. H. Hedrick</u>	24. FUNERAL DIRECTOR <u>JOHN T. STANSBURY</u>	ADDRESS <u>6411 WINDSOR MILL RD BALTO. 7, MD.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## 10661 CERTIFICATE OF DEATH

Item 23, Film 4189 11-23-55 et

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Henryton</u>		<u>7 days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Henryton State Hospital</u>				STREET ADDRESS (If rural give location) <u>1204 Laurens Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Joseph</u> <u>Brickhouse</u>				<u>11</u> <u>17</u> <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Negro</u>	<u>Single</u>	<u>May 30, 1925</u>	<u>30</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Unknown</u>					<u>Baltimore, Maryland</u>		<u>U. S.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Unknown</u>				<u>Annie Brickhouse</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS		
<u>Unk.</u>					<u>Mary I. Howell, R.N., Balto. City Jail</u>		
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
002X IMMEDIATE CAUSE		(A) <u>Far advanced bilateral pulmonary tuberculosis</u>					
ANTECEDENT CAUSE(S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		(B) <u>Meningitis</u>					
STATING UNDERLYING CAUSE LAST.		DUE TO					
027X		(C) <u>Syphilis</u>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
<b>22. I hereby certify</b> that I attended the deceased from <u>Novem. 10, 19 55</u> , to <u>Nov. 17</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Nov. 17</u> , 19 <u>55</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ruane's Epitio Md.</u>				ADDRESS (Street, city, town, state)		DATE SIGNED	
				<u>Henryton State Hospital</u>		<u>11-17-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>11-22-55</u>		<u>Anatomy Board of Md.</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
NOV 21 1955		<u>Albert R. Swankhouse</u>					

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

NOV 21 1955

RECEIVED  
NOV 21 1955

REPLY TO THE  
JANUARY 1964  
EDITION OF  
THE JOURNAL OF  
THE AMERICAN  
PSYCHOLOGICAL  
ASSOCIATION



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10662

## CERTIFICATE OF DEATH

10666

Reg. Dist. No. 76

1. PLACE OF DEATH- COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Pennsylvania</u> COUNTY <u>Adams</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Silver Run</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Littlestown</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Meadowview Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>West King Street</u>	
3. NAME OF DECEASED (First) <u>Melanchthon</u> (Middle) <u>Coover</u> (Last) <u>Coover</u>		4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	8. DATE OF BIRTH <u>Mar. 26, 1861</u>	9. AGE last birthday <u>94</u> yrs. <u>94</u> Months <u>94</u> Days <u>94</u> Hours <u>94</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cambria Co. Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jacob Coover</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Teeter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Donald B. Coover Littlestown Penna.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>hypostatic pneumonia</u>			<u>8 days</u>
Antecedent cause(s) (b) <u>chronic myocardial disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arterio-sclerosis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u> PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)			
HOMICIDE			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar. 1, 1951</u> , to <u>Nov. 21, 1955</u> , that I last saw the deceased alive on <u>Nov. 21, 1955</u> , and that death occurred at <u>5:59 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Donald B. Coover M.D.</u>		ADDRESS <u>Littlestown Pa.</u> DATE SIGNED <u>Nov. 21, 1955</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Nov. 25 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Evergreen Cemetery</u>		LOCATION (City, town, or county) (State) <u>Gettysburg, Adams Co. Pa.</u>	
DATE REC'D BY LOCAL REG. <u>11-22-55</u>		REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	
		24. FUNERAL DIRECTOR <u>Miller &amp; Bender</u> ADDRESS <u>Gettysburg, Pa.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

BUREAU V. S.

NOV 25 1955

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 10663 CERTIFICATE OF DEATH

10667

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Frederick</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (In this place) <u>9 mos. 16 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Brunswick</u>		<u>10-35-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15</u> <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>912 East D Street</u>		<u>✓</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Mabel</u> <u>Naomi</u> <u>CORNELIUS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11</u> <u>30</u> <u>19 55</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Div.</u>	8. DATE OF BIRTH <u>2/16/08</u>	9. AGE last birthday <u>47</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>YMCA</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Chaney</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Spurrier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-32-6266</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>						<u>4 years +</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>4 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/9/55</u> , 19 <u>55</u> , to <u>11/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/29</u> , 19 <u>55</u> , and that death occurred at <u>12:40AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Sonnenfeldt</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>11/30/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Dec 4</u>		NAME OF CEMETERY OR CREMATORY <u>Plain View</u>		LOCATION (City, town, or county) (State) <u>Frederick Co. Md.</u>	
24. REC'D BY REGISTRAR <u>Nov. 30 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Green</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Fritz</u>		ADDRESS <u>Brunswick</u>	



## 10664 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>1 month 24 days</u>		TOWN <u>Baltimore 18</u>		<u>3 Y 0 1-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>North Charles Street</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>LEWIS</u>		(Middle) <u>RANDOLF</u>		(Last) <u>CURLETT</u>		(Month) <u>11</u> (Day) <u>3</u> (Year) <u>19 55</u>	
(Type or Print)							
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Widowed</u>		<u>10-14-78</u>	
<b>9. AGE last birthday</b>		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>77 yrs.</u>		<u>Stationer</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Lewis Grimes Curlett</u>				<u>Mary Allen</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>				<u>74-26</u>		<u>Hospital records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Bilateral Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) <u>Hypertensive cardiovascular disease</u>				<u>years</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>CBS associated with cerebral arteriosclerosis, with psychotic reaction.</u>				<u>4 1/2 yrs. +</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>11-3</u>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<input type="checkbox"/>		<input type="checkbox"/>					
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>10-20</u>, 19 <u>55</u>, to <u>11-3</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11-3</u>, 19 <u>55</u>, and that death occurred at <u>1:45 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Edmund Lusthaus</u>				<u>11-3-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>				<u>Druid Ridge</u>		<u>Pikesville, Md.</u>	
<b>DATE THEREOF</b>		<b>24. REC'D BY REGISTRAR</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>11-5-55</u>		<u>A. Harry Allen</u>		<u>Edmund &amp; Maroon B. 108 W. North Ave.</u>			
<b>DATE</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Nov. 3, 1955</u>		<u>A. Harry Allen</u>		<u>Edmund &amp; Maroon B. 108 W. North Ave.</u>			

INSTRUCTIONS

**1** TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1008

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

# 1900 CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. COLOR

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SERVICE

15. PLACE OF DEATH

16. TIME OF DEATH

17. CAUSE OF DEATH

18. PLACE OF BIRTH

19. COLOR

20. MARITAL STATUS

21. EDUCATION

22. RELIGION

23. SERVICE

24. PLACE OF DEATH

25. TIME OF DEATH

26. CAUSE OF DEATH

27. PLACE OF BIRTH

28. COLOR

29. MARITAL STATUS

30. EDUCATION

31. RELIGION

32. SERVICE

33. PLACE OF DEATH

34. TIME OF DEATH

35. CAUSE OF DEATH

36. PLACE OF BIRTH

37. COLOR

38. MARITAL STATUS

39. EDUCATION

40. RELIGION

41. SERVICE

42. PLACE OF DEATH

43. TIME OF DEATH

44. CAUSE OF DEATH

45. PLACE OF BIRTH

46. COLOR

47. MARITAL STATUS

48. EDUCATION

49. RELIGION

50. SERVICE

51. PLACE OF DEATH

52. TIME OF DEATH

53. CAUSE OF DEATH

54. PLACE OF BIRTH

55. COLOR

56. MARITAL STATUS

57. EDUCATION

58. RELIGION

59. SERVICE

60. PLACE OF DEATH

61. TIME OF DEATH

62. CAUSE OF DEATH

63. PLACE OF BIRTH

64. COLOR

65. MARITAL STATUS

66. EDUCATION

67. RELIGION

68. SERVICE

69. PLACE OF DEATH

70. TIME OF DEATH

71. CAUSE OF DEATH

72. PLACE OF BIRTH

73. COLOR

74. MARITAL STATUS

75. EDUCATION

76. RELIGION

77. SERVICE

78. PLACE OF DEATH

79. TIME OF DEATH

80. CAUSE OF DEATH

81. PLACE OF BIRTH

82. COLOR

83. MARITAL STATUS

84. EDUCATION

85. RELIGION

86. SERVICE

87. PLACE OF DEATH

88. TIME OF DEATH

89. CAUSE OF DEATH

90. PLACE OF BIRTH

91. COLOR

92. MARITAL STATUS

93. EDUCATION

94. RELIGION

95. SERVICE

96. PLACE OF DEATH

97. TIME OF DEATH

98. CAUSE OF DEATH

99. PLACE OF BIRTH

100. COLOR

101. MARITAL STATUS

102. EDUCATION

103. RELIGION

104. SERVICE

105. PLACE OF DEATH

106. TIME OF DEATH

107. CAUSE OF DEATH

108. PLACE OF BIRTH

109. COLOR

110. MARITAL STATUS

111. EDUCATION

112. RELIGION

113. SERVICE

114. PLACE OF DEATH

115. TIME OF DEATH

116. CAUSE OF DEATH

117. PLACE OF BIRTH

118. COLOR

119. MARITAL STATUS

120. EDUCATION

121. RELIGION

122. SERVICE

123. PLACE OF DEATH

124. TIME OF DEATH

125. CAUSE OF DEATH

126. PLACE OF BIRTH

127. COLOR

128. MARITAL STATUS

129. EDUCATION

130. RELIGION

131. SERVICE

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10669

## 10665 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>MD</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		TOWN		TOWN	
TOWN <u>Sykesville</u>		<u>4 yrs 3 mos</u>		<u>Baltimore</u>		<u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>H400 Hammond Ave</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Helen Fieldman</u>				<u>Nov 26 1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Latvian</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Solomon Balonkin</u>				14. MOTHER'S MAIDEN NAME <u>Chana</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
491X IMMEDIATE CAUSE (A) <u>Bilateral Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic nephrosclerosis</u>				<u>years</u>			
<u>Psychosis with Arteriosclerosis</u>				<u>"</u>			
19a. DATE OF OPERATION <u>27</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug 22, 1951</u> , to <u>Nov 26, 1955</u> , that I last saw the deceased alive on <u>Nov 26, 1955</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ellis J. Margher</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-28-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebrew Mt Carmel</u>		LOCATION (City, town, or county) (State) <u>Bald Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Uker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis, Inc.</u>		ADDRESS <u>2100 E. Main St.</u>	
DATE <u>Nov 27, 1955</u>							

# INSTRUCTIONS

1. This form is to be filled out by the physician or other person who has attended the deceased. It should be filled out as soon as possible after death, and should be submitted to the local health officer or to the Bureau of Health Statistics, State Department of Health, Washington, D. C., as soon as possible.

2. The information furnished on this form is for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

3. The information furnished on this form is to be used for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

4. The information furnished on this form is to be used for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

5. The information furnished on this form is to be used for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

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9. The information furnished on this form is to be used for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

10. The information furnished on this form is to be used for the purpose of determining the cause of death, and for the purpose of compiling statistics on the causes of death. It is not to be used for any other purpose.

## 1905 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

100000

1. USUAL RESIDENCE (NAME OF DECEASED)

MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

STREET NO. 1234

WARD NO. 1

PRECINCT NO. 1

WATER

SEWER

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INSTRUCTIONS

I

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10670

## 10666 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>26Y-5M-18D</u>		TOWN <u>Takoma Park, Md.</u>		<u>15-17-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15 Springfield State Hospital</u>				<u>13 Allegheny Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>John</u> (Middle) <u>Findlay</u> (Last)				(Month) <u>11</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		
<u>M</u>	<u>W</u>	<u>married</u>	<u>9-20-1874</u>	<u>81</u> yrs.	Months	Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>plasterer</u>		<u>unk</u>		<u>Scotland</u>		<u>unk</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Findlay</u>				<u>Elizabeth Gray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>unk</u>		<u>unk</u>		<u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO						<u>years</u>	
(B) <u>Arteriosclerotic heart disease</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>26 years -</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 20, 1954</u> , to <u>Nov. 5, 1955</u> , that I last saw the deceased alive on <u>Nov. 5, 1955</u> , and that death occurred at <u>8:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edmund Lustman</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>Nov. 6, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>CREMATION</u>		<u>11/7/55</u>		<u>CEDAR HILL CREMATORY</u>		<u>PRINCE GEORGE CO, MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 7, 1955</u>		<u>C. Harry Wheeler</u>		<u>J. Arthur Walters</u>		<u>254 Carroll St. Md DC</u>	

# NOTIFICATION

1. This form is to be filled out by the physician or other person who has attended the deceased, and is to be filed in the office of the Registrar of the Department of Health, Baltimore, Maryland, within ten days of the date of death. It is to be filled out in duplicate, and the original is to be retained by the Registrar, and the duplicate is to be returned to the person who has attended the deceased.

## 1908 CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. One 14

1. Name of deceased

2. Place of birth

3. Date of birth

4. Sex

5. Race

6. Occupation

7. Cause of death

8. Date of death

9. Place of death

10. Signature of physician

11. Signature of registrar

12. Name of informant

13. Address of informant

14. Date of notification

15. Name of informant

16. Address of informant

17. Date of notification

18. Name of informant

19. Address of informant

20. Date of notification

21. Name of informant

22. Address of informant

23. Date of notification

24. Name of informant

25. Address of informant

26. Date of notification

27. Name of informant

28. Address of informant

29. Date of notification

30. Name of informant

31. Address of informant

32. Date of notification

33. Name of informant

34. Address of informant

35. Date of notification

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74. Date of notification

73. Name of informant

74. Address of informant

75. Date of notification

74. Name of informant

75. Address of informant

76. Date of notification

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10667 CERTIFICATE OF DEATH

10671

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Rural, Nr. Westminster</b>		<b>Life</b>		TOWN <b>Rural, Nr. Westminster</b>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Westminster, Md. R.D.1		STREET ADDRESS		Uniontown District Westminster, Md. R.D.1	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Mary B. Foglesong</b>				<b>11/27/55</b> 19			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Female</b>	<b>White</b>	<b>Widowed</b>	<b>5/3/1878</b>	<b>77</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Housewife, Housework</b>		<b>Family home.</b>		<b>Carroll County, Md.</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Francis T. Brown</b>				<b>Lavina Feeser</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>No.</b>		<b>None</b>		<b>Francis E. Foglesong, Westminster, Md. R.D.1</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>794X IMMEDIATE CAUSE (A)</b> <b>General waste</b>							
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Senile decay, mental</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/></b>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from June 7, 1955, to Nov 26, 1955, that I last saw the deceased alive on Nov 26, 1955, and that death occurred at 8 A.M. from the causes and on the date stated above. 11-27-55</b>							
<b>SIGNATURE</b> <b>J. H. Legg, M.D.</b>				<b>ADDRESS (Street, city, town, state)</b> <b>Union Bridge, Carroll Md</b>		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>11/30/55</b>		<b>St. Marys Cemetery</b>		<b>Silver Run, Carroll Co., Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>11/29/55</b>		<b>Margaret R. Englar</b>		<b>H. M. Littlejohn</b>		<b>Littlestown, Pa.</b>	



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MARYLAND

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STATE DEPARTMENT OF HEALTH

## 10668 CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH - COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winfield</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winfield</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>apais</u>		STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JAMES</u>	(Middle) <u>ROBERT</u>	(Last) <u>FRANKLIN</u>
4. DATE OF DEATH	(Month) <u>Nov</u>	(Day) <u>17</u>	(Year) <u>1955</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>single</u>	8. DATE OF BIRTH <u>9 Dec 1881</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>by day</u>	9. AGE last birthday <u>73</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. FATHER'S NAME <u>James J. Franklin</u>	14. MOTHER'S MAIDEN NAME <u>Catherine Farver</u>	13. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>
16. SOCIAL SECURITY No. <u>218-10-8518</u>	17. INFORMANT AND ADDRESS <u>Oral B. Franklin, Winfield, Md.</u>		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

260x Immediate cause (a) Cardiac arrest, Cerebral Thrombosis.

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) arteriosclerosis, diabetes mellitus (mild)II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1 Nov, 1955, to 17 Nov, 1955, that I last saw the deceasedalive on 17 Nov, 1955, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE

Howard E. Ball M.D.

ADDRESS

Sykesville, Md.

DATE SIGNED

17 Nov 55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>11/20/55</u>	<u>Cheney Cem.</u>	<u>Winfield, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>11-19-55</u>	<u>E.M. Farver</u>	<u>D.D. Hartzler &amp; Sons</u>	<u>New Windsor, Md.</u>	

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10673

## 10669 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>39yr. 10mo. 23days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>Ynk -</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>BERNARD</u> (First) <u>FRYNCKO</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>1</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>2-11-92</u>	<b>9. AGE last birthday</b> <u>63</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Ynk -</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Antone Fryncko</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Pretre</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>002X Far-advanced bilateral pulmonary tuberculosis, active.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Dementia Praecox, Catatonic type.</u>						<u>40 yrs. +</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>10-17</u> , 19 <u>55</u> , <b>to</b> <u>11-1</u> , 19 <u>55</u> , <b>that I last saw the deceased</b> <u>alive on</u> <u>11-1</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>10:10AM</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Eugene Lushan</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Springfield State Hosp., Sykesville</u>		<b>DATE SIGNED</b> <u>11-1-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>No. 4-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Holy Redeemer</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balto Md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Recd. 1.1955</u>		<u>C. Hanytman</u>		<u>Wm Cook Inc 12175th Road</u>			

# DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

Form No. 10-1

1. DECEASED'S RESIDENCE (HOUSE OR CHURCH)

MARYLAND

County of \_\_\_\_\_

2. DECEASED'S NAME (Last, first, and middle)

John Doe

Age \_\_\_\_\_

3. DECEASED'S SEX (Male or Female)

Male

Color \_\_\_\_\_

4. DECEASED'S OCCUPATION

Farmer

Married \_\_\_\_\_

5. DECEASED'S DATE OF BIRTH

Jan 1, 1900

Place of Birth \_\_\_\_\_

6. DECEASED'S DATE OF DEATH

Nov 1, 1950

Time of Death \_\_\_\_\_

7. DECEASED'S CAUSE OF DEATH

Heart Disease

Signature of Doctor \_\_\_\_\_

8. DECEASED'S PLACE OF DEATH

Home

Signature of Coroner \_\_\_\_\_

9. DECEASED'S PLACE OF INTERMENT

Cemetery

Signature of Minister \_\_\_\_\_

10. DECEASED'S PLACE OF BURIAL

Cemetery

Signature of Undertaker \_\_\_\_\_

11. DECEASED'S PLACE OF CREMATION

Crematorium

Signature of Cremator \_\_\_\_\_

12. DECEASED'S PLACE OF EXHUMATION

Cemetery

Signature of Exhumator \_\_\_\_\_

13. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

14. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

15. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

16. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

17. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

18. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

19. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

20. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

21. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

22. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

23. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

24. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

25. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

26. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

27. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

28. DECEASED'S PLACE OF REINTERMENT

Cemetery

Signature of Reinterment Officer \_\_\_\_\_

NOTES

1. This certificate is to be filled out by the attending physician or the coroner, and it is to be signed by the physician or coroner, and it is to be filed in the office of the State Department of Health, Baltimore, Maryland.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10674

## 10670 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>1Y 10M 24D</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15</u> <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3814 Cranston Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elizabeth</u> <u>Mohr</u> <u>Geisendaffer</u>				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>11</u> (Year) <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>12-15-1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lawrence Mohr</u>				14. MOTHER'S MAIDEN NAME <u>(adopted) Stack</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Myocardial degeneration</u>						<u>weeks</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. brain syndr. ass. with senile brain disease</u>							
<u>circ. disorder, cerebral arterioscl. with psych. react.</u>						<u>11 months</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Dec. 1954</u> , 19....., to <u>November 11, 1955</u> , that I last saw the deceased alive on <u>Nov. 11, 1955</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edmund Lusthaus</u>				M.D. <u>Sykesville, S.S. Hospital</u>		DATE SIGNED <u>11-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 14/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Lee</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Henry</u>		ADDRESS <u>2024 Orleans St. 31</u>	

10070

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

# 10070 CERTIFICATE OF DEATH

Form 10070-10

1. DECEASED'S NAME (PRINT OR TYPE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. REMARKS (PRINT OR TYPE)

BUREAU V. S.

1955

RECEIVED

1955

1955

1955

20070-10

1. DECEASED'S NAME (PRINT OR TYPE)  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. PLACE OF DEATH  
10. DATE OF DEATH  
11. TIME OF DEATH  
12. SIGNATURE OF PHYSICIAN  
13. SIGNATURE OF REGISTRAR  
14. SIGNATURE OF WITNESSES  
15. SIGNATURE OF DECEASED  
16. REMARKS (PRINT OR TYPE)



**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10671 **CERTIFICATE OF DEATH**

10675

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>6 days</u>		TOWN <u>Baltimore (11)</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2815 Hamden Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>BLANCHE AUGUSTA HAINES</u>				<u>November 14 1955</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Female</u>		<u>White</u>		<u>Single</u>		<u>1-13-74</u>	
<b>9. AGE last birthday</b>		<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>			
<u>81 yrs.</u>		Months Days		Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)	
<u>Housework</u>						<u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<u>U.S.A.</u>			
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Levi Haines</u>				<u>Laura Ensor</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>No</u>						<u>Hospital records</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>C.B.S. due to cerebral arteriosclerosis</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>11-12</u>, 19<u>55</u>, to <u>11-14</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11-13</u>, 19<u>55</u>, and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)			
<u>Walther H. Sommersfeldt</u>				<u>M.D. Springfield State Hosp. - Sykesville 11-14-55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>11/16/55</u>		<u>St. Mary's Cemetery</u>		<u>Hampden, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>NOV 16 1955</u>		<u>C. Harry Jones</u>		<u>Wm. J. Trubner &amp; Sons - North Pa. Ave</u>		<u>Balto-12, Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10672 **CERTIFICATE OF DEATH**

10676

Reg. Dist. No. 74

Items 1, 4, &amp; 22 Film G190 12/12/55 mnb

**1. PLACE OF DEATH**COUNTY **Carroll**

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
and give nearest town)X **Rural - Sykesville**LENGTH OF STAY  
(In this place)

10 M, 10 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS15 **Springfield State Hospital****2. USUAL RESIDENCE (HOME) OF DECEASED**STATE **Maryland**

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN **Baltimore**STREET  
ADDRESS

1713 Byrd Street

(If rural give location)

**3. NAME OF  
DECEASED**  
(Type or Print)

(First)

**David**

(Middle)

**William**

(Last)

**HALL****4. DATE** (Month)**11**

(Day)

**8**

(Year)

**19****55****5. SEX****Male****6. COLOR OR  
RACE****White****7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)****Widowed****8. DATE OF BIRTH****11/12/69****9. AGE last birthday****85**

yrs.

**IF UNDER 1 YEAR**

Months

Days

**IF UNDER 24 HRS.**

Hours

Min.

**10a. USUAL OCCUPATION** (Give kind of work  
done during most of working life, even if  
retired)**Engineer****10b. KIND OF BUSINESS  
OR INDUSTRY****Railroad****11. BIRTHPLACE** (State or foreign country)**Maryland****12. CITIZEN OF WHAT  
COUNTRY?****USA****13. FATHER'S NAME****Jess Hall****14. MOTHER'S MAIDEN NAME****Elizabeth DeLauder****15. WAS DECEASED EVER IN U. S. ARMED FORCES?**  
(Yes, no, or unk.) (If Yes, give war or dates of service)**unknown****16. SOCIAL SECURITY NO.****17. INFORMANT & ADDRESS****Record, Springfield State Hospital****I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

260X IMMEDIATE CAUSE (A)

**Myocardial infarct due to coronary thrombosis****INTERVAL BETWEEN  
ONSET AND DEATH****minutes**

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(B)

**Hypertensive arteriosclerotic vascular disease****years**

(C)

**Diabetes Mellitus****years****II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.****Chronic brain syndrome associated with senile  
brain disease, with psychotic reaction****3 years****19a. DATE OF OPERATION****19b. MAJOR FINDINGS OF OPERATION****20. AUTOPSY?**YES ☐ NO ☒**21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)****21b. PLACE** (Home, farm, factory,  
OF INJURY street, office bldg., etc.)**21c. WHERE DID INJURY OCCUR?** (City or town)

(County)

(State)

**21d. TIME OF INJURY** (Month) (Day) (Year) (Hour)**21e. INJURY OCCURRED**While ☐Not while ☐at work ☐at work ☐**21f. HOW DID INJURY OCCUR?****22. I hereby certify that I attended the deceased from 4/18, 1955, to 11/3, 1955, that I last saw the deceased****alive on 11/3, 1955, and that death occurred at 8:45AM, from the causes and on the date stated above.****SIGNATURE****Edmund Luthans M.D.****ADDRESS** (Street, city, town, state)**Sykesville, Maryland****DATE SIGNED****11/3/55**

(State)

**23. BURIAL, CREMATION,  
REMOVAL (Specify)****DATE THEREOF****11-5-55****NAME OF CEMETERY OR CREMATORY****London Park****LOCATION** (City, town, or county)**Balto****24. REC'D BY REGISTRAR****REGISTRAR'S SIGNATURE****Harry [Signature]****25. FUNERAL DIRECTOR'S SIGNATURE****ADDRESS****McCully Funeral Homes  
130 E. Fort Ave.**

DATE

**11/3/55**

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

## 10673 CERTIFICATE OF DEATH

### FOR MEDICAL EXAMINERS

10677

Reg. Dist. No. 81

<b>1. PLACE OF DEATH</b> COUNTY <u>Carroll</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg - Rural</u> TOWN <u>Middleburg</u> (in this place) HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b> STATE <u>Maryland</u> COUNTY <u>Carroll</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u> TOWN <u>Middleburg</u> STREET ADDRESS (If rural, give location) <u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>HAYDEN</u> <u>MONROE</u> <u>HANN</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>11</u> , 19 <u>55</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>M</u>	<b>8. DATE OF BIRTH</b> <u>Sept 24 - 1916</u>
<b>9. AGE last birthday</b> <u>39</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Hayden L. Hann</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Hannah Plaine</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY No.</b> <u>220-01-2022</u>	
<b>17. INFORMANT</b> <u>Margaret K. Hann, Middleburg, Md</u>			
<b>18. MEDICAL CERTIFICATION</b>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>802X</u> Immediate cause (a) <u>Compound comminuted fracture skull - face -</u> Antecedent cause(s) (b) <u>/</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>/</u>			<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Instant</u>
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		<b>21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> PLACE (Home, farm, factory, street, office, bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) <u>INJURY Railroad - Western Md. Middleburg Carroll Co Md</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov 11 - 1953 2 PM.</u>		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR? <u>Struck by railroad train</u>	
<b>22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/>, accident <input checked="" type="checkbox"/>, suicide <input type="checkbox"/>, homicide <input type="checkbox"/>, undetermined <input type="checkbox"/>.</b>			
<b>SIGNATURE</b> (Degree or title) <u>James J. March, Deputy Medical Examiner - Westminster Md</u>		<b>ADDRESS</b> <u>11/12/55</u>	
<b>23. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Nov 14 - 1955</u>	
<b>NAME OF CEMETERY OR CREMATORY</b> <u>Haugh's Church</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Fredrick Co. Md</u>	
<b>DATE REC'D BY LOCAL REG.</b> <u>Nov. 13, 1953</u>		<b>24. FUNERAL DIRECTOR</b> <u>D. H. Hartzler &amp; Sons, Union Bridge, Md</u>	

1955  
BUREAU V. S.

NOV 15 1955

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9, Film 189 11-16-55 et

10674

## CERTIFICATE OF DEATH

10678

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (In this place) <u>1Y, 2M, 9 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore-31</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>415 South Wolfe Street</u>			
<b>3. NAME OF DECEASED</b> (First) <u>JOHN</u> (Middle) <u>(alias Michael Adams)</u> (Last) <u>HARDESTY</u>				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>4</u> (Year) <u>19 55</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married?</u>	8. DATE OF BIRTH <u>unknown</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>	
13. FATHER'S NAME <u>Possibly Wm. Augustine Adams</u> <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>Arteriosclerotic heart disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive and/or cardiovascular disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Pulmonary emphysema</u>						<u>years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome assoc. with cerebral arterio-sclerosis with psychotic reaction</u>						<u>unknown</u>	
19a. DATE OF OPERATION <u>10/20/55</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/26</u> , 19 <u>55</u> , to <u>11/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/3</u> , 19 <u>55</u> , and that death occurred at <u>7:10AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edmund Lusthaus</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>11/4/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 8, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Henry Alcar</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVENUE</u>			

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN IN CHARGE OF THE HOSPITAL AND FOUND TO BE IN GOOD HEALTH AND FIT TO RETURN TO HIS HOME OR PLACE OF RESIDENCE. THE PHYSICIAN'S SIGNATURE AND SEAL ARE HEREBY AFFIXED TO THIS CERTIFICATE.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

10678

REG. NO. 10678

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. PREVIOUS ILLNESS

14. MEDICAL HISTORY

15. PHYSICIAN'S SIGNATURE

16. HOSPITAL'S SIGNATURE

17. PHYSICIAN'S SEAL

18. HOSPITAL'S SEAL

19. PHYSICIAN'S ADDRESS

20. HOSPITAL'S ADDRESS

21. PHYSICIAN'S PHONE

22. HOSPITAL'S PHONE

23. PHYSICIAN'S FAX

24. HOSPITAL'S FAX

25. PHYSICIAN'S EMAIL

26. HOSPITAL'S EMAIL

27. PHYSICIAN'S SIGNATURE

28. HOSPITAL'S SIGNATURE

29. PHYSICIAN'S SEAL

30. HOSPITAL'S SEAL

31. PHYSICIAN'S ADDRESS

32. HOSPITAL'S ADDRESS

33. PHYSICIAN'S PHONE

34. HOSPITAL'S PHONE

35. PHYSICIAN'S FAX

36. HOSPITAL'S FAX

37. PHYSICIAN'S EMAIL

38. HOSPITAL'S EMAIL

39. PHYSICIAN'S SIGNATURE

40. HOSPITAL'S SIGNATURE

41. PHYSICIAN'S SEAL

42. HOSPITAL'S SEAL

43. PHYSICIAN'S ADDRESS

44. HOSPITAL'S ADDRESS

BUREAU V. S.

RECEIVED

NOV 10 1995

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10675

## CERTIFICATE OF DEATH

10679

Reg. Dist. No. 80

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Near New Windsor</u>		<u>4 weeks</u>		TOWN <u>Rural Westminster</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last)							
<u>Carrie Belle Heiner</u>				<u>November 1, 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>April 29, 1875</u>	<u>80</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housework</u>		<u>Own home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William F. Six</u>				<u>Mary Catherine Stambaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>220-24-1103</u>		<u>Mrs. George Miller, New Windsor, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
4221 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>10/6</u> , 19 <u>55</u> , to <u>Nov 1</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-1-</u> , 19 <u>55</u> , and that death occurred at <u>6:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>J. N. Legg</u>				<u>Bluesburg, Md</u>		<u>11-2-55</u>	
M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Nov. 4, 1955</u>		<u>Pleasant Valley Cemetery</u>		<u>Pleasant Valley, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov 7-55</u>		<u>Ennis B. Benedict</u>		<u>Merwyn C. Fuss</u>		<u>Taneytown, Maryland</u>	

10878

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# 10878 CERTIFICATE OF DEATH

State of Maryland

County of Baltimore

City of Baltimore

Ward of Baltimore

Block of Baltimore

Lot of Baltimore

Household of Baltimore

Age of Deceased

Sex of Deceased

Color of Deceased

Marital Status of Deceased

Occupation of Deceased

Education of Deceased

Religion of Deceased

Place of Birth of Deceased

Date of Birth of Deceased

Place of Death of Deceased

Date of Death of Deceased

Cause of Death of Deceased

Manner of Death of Deceased

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

Signature of Witness

Signature of Minister

Signature of Burial Officer

Signature of Undertaker

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

Signature of Witness

Signature of Minister

Signature of Burial Officer

Signature of Undertaker

Signature of Cemetery

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

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Signature of Interment

Signature of Burial

Signature of Interment

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Deceased

Signature of Next of Kin

Signature of Witness

Signature of Minister

Signature of Burial Officer

Signature of Undertaker

Signature of Cemetery

Signature of Burial

Signature of Interment

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10676 CERTIFICATE OF DEATH

10680

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		STATE <u>Md.</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>4/1/55</u>		TOWN <u>Westminster</u>		<u>27</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hosp.</u>				STREET ADDRESS (If rural give location) <u>88 West main st.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Elmer</u>		(Middle) <u>Warren</u>		(Last) <u>Hesson</u>		(Month) (Day) (Year) <u>11 4 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>9/1/1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Blacksmith</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Hesson</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Myers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Records of S.S. Hosp.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4500 IMMEDIATE CAUSE (A) <u>HEAVY Broncho-pneumonia</u>						12 days	
ANTECEDENT CAUSE(S) DUE TO (B) <u>General Arteriosclerosis</u>						10 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Chronic brain syndrome Associated with senile brain disease</u>						10 yrs.	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>from Oct 9 20</u> , to <u>Nov 4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/4/55</u> , 19 <u>55</u> , and that death occurred at <u>10:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edmund Luthan</u> M.D.				ADDRESS (Street, city, town, state)		DATE SIGNED <u>11/4/55</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 7, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Krider's</u>		LOCATION (City, town, or county) <u>nr Westminster, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Wilson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Byers</u>		ADDRESS <u>Westminster, Md.</u>	
DATE <u>Nov. 5, 1955</u>							







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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10654 **CERTIFICATE OF DEATH**

10681

Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>		LENGTH OF STAY (in this place) <u>33 YRS.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 45 WEBSTER</u>				STREET ADDRESS <u>45 WEBSTER</u>		<u>1</u>	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>GRACE EDNA ISLES</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11-8-1955</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOW</u>	<b>8. DATE OF BIRTH</b> <u>FEB. 16-1885</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>NOT KNOWN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>NOT KNOWN</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>JOHN W. HYDER, 45 WEBSTER ST. WESTMINSTER, MD.</u>		
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>592X IMMEDIATE CAUSE</b> (A) <u>Myocarditis (chr.)</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Nephritis (chr.)</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Hypertension</u>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20. DATE OF OPERATION</b>				<b>20. DATE OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>			<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>May 1940</u> <b>to</b> <u>Nov 8, 1955</u> <b>that I last saw the deceased alive on</b> <u>Nov 7, 1955</u> <b>and that death occurred at</b> <u>5:10 P.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>W. E. Isenhardt</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Westminster Md</u>		<b>DATE SIGNED</b> <u>11-9-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>11-10-1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>WESTMINSTER CEM.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Hazel Miller</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H. B. Bankard</u>			
<b>DATE</b> <u>11-12-55</u>		<b>ADDRESS</b> <u>Son Westminster Md.</u>					

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

# 1955 CERTIFICATE OF DEATH

1955

Reg. No. 100-100

1. NAME OF DECEASED (Print or Type)

2. SEX (M or F)

3. AGE (Years and Months)

4. DATE OF BIRTH (Month, Day, Year)

5. PLACE OF BIRTH (City, State, Country)

6. OCCUPATION (Print or Type)

7. MARITAL STATUS (M, S, W, D, O, C, P, R, U, V, N, A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, V, W, X, Y, Z)

8. DATE OF DEATH (Month, Day, Year)

9. TIME OF DEATH (Hour, Minute)

10. PLACE OF DEATH (City, State, Country)

11. CAUSE OF DEATH (Print or Type)

12. MANNER OF DEATH (Print or Type)

13. SIGNATURE OF PHYSICIAN (Print or Type)

14. SIGNATURE OF REGISTRAR (Print or Type)

15. SIGNATURE OF WITNESS (Print or Type)

16. SIGNATURE OF DECEASED (Print or Type)

17. SIGNATURE OF NEXT OF KIN (Print or Type)

18. SIGNATURE OF CLERK (Print or Type)

19. SIGNATURE OF CHURCH CLERK (Print or Type)

20. SIGNATURE OF BURIAL CLERK (Print or Type)

21. SIGNATURE OF CREMATOR (Print or Type)

22. SIGNATURE OF OTHER (Print or Type)

23. SIGNATURE OF OTHER (Print or Type)

24. SIGNATURE OF OTHER (Print or Type)

25. SIGNATURE OF OTHER (Print or Type)

26. SIGNATURE OF OTHER (Print or Type)

27. SIGNATURE OF OTHER (Print or Type)

28. SIGNATURE OF OTHER (Print or Type)

29. SIGNATURE OF OTHER (Print or Type)

30. SIGNATURE OF OTHER (Print or Type)

BUREAU V. S.

NOV 19 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10677 **CERTIFICATE OF DEATH**

10682

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY OR TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>1 M, 19 days</u>		CITY OR TOWN <u>Hagerstown</u>		<u>21-03-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS <u>618 Sunset Avenue</u>		(If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <u>LAURA VIRGINIA KEMP</u>				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1/29/75</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles H. Wolfe</u>				14. MOTHER'S MAIDEN NAME <u>Emma Bodine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk.</u>		16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <u>Record, Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
446X IMMEDIATE CAUSE (A) <u>Uremia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Nephrosclerosis</u>				<u>weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Generalized arteriosclerosis</u>				<u>years</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>				<u>2 years</u>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
<b>22. I hereby certify that I attended the deceased from <u>10/23</u>, 19 <u>55</u>, to <u>11/2</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11/1</u>, 19 <u>55</u>, and that death occurred at <u>6:35A</u> AM, from the causes and on the date stated above.</b>							
SIGNATURE <u>Edmund L. Nathan</u>		DATE THEREOF <u>11-4-55</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		LOCATION (City, town, or county) <u>Hagerstown, Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>C. Harry Allen</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Scott H. Minnick</u>		ADDRESS <u>Sykesville, Maryland</u>	
DATE <u>11-2-55</u>		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	

BUREAU A 3

C45A

## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**1** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10683

10678 **CERTIFICATE OF DEATH**Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>4 mos. 29 days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3000 Ellerslie Avenue</u> ✓			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Ella Mae KIDWELL</u>				<u>11 2 19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>F</u>	<u>W</u>	<u>Married</u>	<u>April 28, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Bookbinder</u>			<u>unk</u>		<u>Cincinnati, Ohio</u>		<u>USA</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John J. Walsh</u>				<u>Mary Clifford</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<u>unk</u>			<u>unk</u>		<u>Record, Springfield State Hospital</u>		
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>331X</u> IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>years</u>	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Bronchopneumonia</u>						<u>3 days</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>1 year</u>	
<u>chronic brain syndrome associated with cerebral arteriosclerosis, with psychosis</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>11/1</u>, 19 <u>55</u>, to <u>11/2</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11/2</u>, 19 <u>55</u>, and that death occurred at <u>6:35A</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>Edmund Sustan</u> M.D.				<u>Sykesville, Maryland</u>		<u>11/2/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Nov. 5, 1955</u>		<u>Holy Redeemer Cemetery</u>		<u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS</b>			
<u>Nov. 2, 1955</u>		<u>C. Harry Weer</u>		<u>Leonard J. Ruck, 5305 Harford Road # 14</u>			



# 10078 CERTIFICATE OF DEATH

Reg. No. 1010

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

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29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

31. SIGNATURE OF INTERVIEWER

32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CEMETERY

19. SIGNATURE OF INTERVIEWER

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

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32. SIGNATURE OF INTERVIEWER

33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

35. SIGNATURE OF INTERVIEWER

21078100781

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF NEXT OF KIN  
15. SIGNATURE OF CLERGYMAN  
16. SIGNATURE OF BURIAL OFFICIAL  
17. SIGNATURE OF FUNERAL HOME  
18. SIGNATURE OF CEMETERY  
19. SIGNATURE OF INTERVIEWER  
20. SIGNATURE OF INTERVIEWER  
21. SIGNATURE OF INTERVIEWER  
22. SIGNATURE OF INTERVIEWER  
23. SIGNATURE OF INTERVIEWER  
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33. SIGNATURE OF INTERVIEWER  
34. SIGNATURE OF INTERVIEWER  
35. SIGNATURE OF INTERVIEWER

BUREAU A. 10078100781

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 11 &amp; 12, Film G190, 12/7/55 bh

10679

## CERTIFICATE OF DEATH

10684

Reg. Dist. No. 75

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Pennington</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		LENGTH OF STAY (in this place) <u>3 1/2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hanover</u>		<u>75 X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Longview Nursing Home</u>				STREET ADDRESS (If rural give location) <u>316 Fulton St</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mary</u> (First) <u>Kiser</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> <u>Nov. 29</u> 19 <u>55</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>	8. DATE OF BIRTH <u>Feb 24, 1868</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Rulthouse</u>				14. MOTHER'S MAIDEN NAME <u>Martha S. ANGEL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT & ADDRESS <u>Miss Edna Kiser, Hanover Pa.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>19. MEDICAL CERTIFICATION</b>	
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio-sclerotic Cardiac Vascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>-</u>		19b. MAJOR FINDINGS OF OPERATION <u>-</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>-</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>-</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>October 19, 1955</u> , to <u>Nov 29, 1955</u> , that I last saw the deceased alive on <u>Nov 29, 1955</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city, town, state) <u>Hampstead Md</u>		DATE SIGNED <u>Nov 29 1955</u> (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec 2 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Reformed Cemetery</u>		LOCATION (City, town, or county) <u>Taneytown, Md.</u>	
24. REC'D BY REGISTRAR <u>Nov 29 55</u>		REGISTRAR'S SIGNATURE <u>Wm. H. S. Deemer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Dennis R. D. Wetzel</u>		ADDRESS <u>Hanover, Pa.</u>	

10000 CERTIFICATE OF DEATH

1. NAME OF DECEASED (PRINT OR TYPE)

PLACE ON FILE

2. SEX (PRINT OR TYPE)

DATE OF BIRTH

3. PLACE OF BIRTH

4. RACE (PRINT OR TYPE)

5. OCCUPATION

6. CAUSE OF DEATH (PRINT OR TYPE)

7. MANNER OF DEATH (PRINT OR TYPE)

8. MEDICAL CERTIFICATION

BUREAU V. S.

DEC 1 1935

RECEIVED

INTELLIGENCE

## INSTRUCTIONS

**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10680 CERTIFICATE OF DEATH

10685

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>21 Y, 20 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Manchester, Maryland</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15</u> <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Cecelia M. Kreitzer</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11</u> <u>14</u> <u>19 55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>single</u>	<b>8. DATE OF BIRTH</b> <u>1/29/85</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>none</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>none</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William Kreitzer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Barbara Follmer</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Record, Springfield State Hospital</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>IMMEDIATE CAUSE</b> (A) <u>Bronchopneumonia</u>						<u>about 3 days</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Obstruction of common + cystic ducts</u>						<u>about 1 month</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>Chronic cholecystitis with lithiasis</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic brain syndrome associated with epileptic deterioration</u>						<u>years</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>10/25</u> , 19 <u>55</u> , to <u>11/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/14</u> , 19 <u>55</u> , and that death occurred at <u>3:42 PM</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Walther H. Sonnenfeldt</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Sykesville, Maryland</u>		<b>DATE SIGNED</b> <u>11/14/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Nov 17/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Manchester</u>		<b>LOCATION (City, town, or county)</b> <u>Carroll co md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry New</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw C Tipton</u>		<b>ADDRESS</b> <u>Hampstead md</u>	
<b>DATE</b> <u>Nov. 17, 1955</u>							



## 10681 CERTIFICATE OF DEATH

Reg. Dist. No. 81

## 1. PLACE OF DEATH:

COUNTY Carroll MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Union Bridge LENGTH OF STAY (in this place) years  
 TOWN Union Bridge  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Stoner St.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Carroll  
 CITY (If outside corporate limits, write RURAL and give nearest town) Union Bridge  
 TOWN Union Bridge  
 STREET ADDRESS (If rural give location) Stoner St.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HARRYAUGUSTUS LAMBERT

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Nov. 119 55

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days Hours Min.

male whitemarried1/5/187085 yrs.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY:

retiredownerMarylandU.S.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

Augustus LambertRebecca Stultz

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

nonoJosephine L. Lambert, Union Bridge, Md.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

500X  
Immediate cause

(a) DUE TO

## Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Acute Bronchitis  
Smear Phlegm

Interval Between Onset And Death

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

## INJURY OCCURRED

While at Work ☐Not While At Work ☐

## HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Oct 28, 1955, to Nov 1, 1955, that I last saw the deceasedalive on Nov 1, 1955, and that death occurred at 4:30 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Nov 2, 1955 Leslie K. KelpW. D. Hartman & SonsUnion Bridge, Md.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

NOV 3 1955

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10687

## 10682 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Carroll</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Lylesville</i>		<i>2 days</i>		TOWN <i>Baltimore</i>		<i>3Y01-4Y</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<i>15 Springfield State Hospital</i>				<i>3237 E. Baltimore St.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Elizabeth</i> (Middle) <i>Schaefer</i> (Last) <i>Leimbach</i>				(Month) <i>11</i> (Day) <i>26</i> (Year) <i>1955</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify)	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>f.</i>	<i>White</i>	<i>Widowed</i>	<i>10.6.61</i>	<i>94</i>	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Securities</i>		<i>Clothing</i>		<i>Baltimore, Md.</i>		<i>USA</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>John Schaefer</i>				<i>Margaretta Bauer</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<i>unk</i>		<i>unk -</i>		<i>Ms. Adasell Frenk, 6302 Beech Av. Baltimore 6</i>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.0 IMMEDIATE CAUSE</b> (A) <i>Heart failure</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <i>A. S. H. D.</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <i>General Atherosclerosis</i>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>C. B. S.</i>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify</b> that I attended the deceased from <i>11.24</i> , 19 <i>55</i> , to <i>11.26</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11.26</i> , 19 <i>55</i> , and that death occurred at <i>7:20 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b>		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>			
<i>Walter H. Sommerfeld</i>		<i>Lylesville, Md.</i>		<i>11-27-55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>BURIAL</i>		<i>Nov. 29, 1955</i>		<i>LOUDON PARK</i>		<i>BALTIMORE, MARYLAND</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>DATE 11-27-55</i>		<i>C. Henry Weber</i>		<i>William Cook, Jr.</i>		<i>1217 ST. PAUL ST</i>	

BUREAU V. S.

1955 30 NOV

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10688

10683

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>12y 10m 2 d</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mary</u> <u>May</u> <u>Linton</u>				<b>4. DATE OF DEATH</b> <u>11</u> <u>3</u> <u>1955</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>11-20-1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Williams</u>				14. MOTHER'S MAIDEN NAME <u>????</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>unk</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Myocardial Degeneration</u>				INTERVAL BETWEEN ONSET AND DEATH <u>weeks</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Pulmonitis (unknown etiology)</u> <u>4 weeks +</u>			
(C) <u>Anemia unknown etiology</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH <u>Manic depressive psychosis, depressed phase</u>				<u>12 years +</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>October 12, 1955</u> to <u>Novemb. 3, 1955</u> , that I last saw the deceased alive on <u>Nov. 3 rd, 1955</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edmund Lusthaus</u> M.D.				ADDRESS (Street, city, town, state) <u>Sykesville, Maryland</u>		DATE SIGNED <u>11-3-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-6-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 5, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Wynn</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz</u>		ADDRESS <u>Winfield, Maryland</u>	



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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10684

## CERTIFICATE OF DEATH

10689

Reg. Dist. No. 26

1. PLACE OF DEATH (Myers District)				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Penna.</b>		COUNTY <b>Adams</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Rural, Union Mills</b>		<b>6 Weeks</b>		TOWN <b>Littlestown</b>		<b>75X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS (Westminster, Md. R.D.1)				STREET ADDRESS (If rural give location)			
90 Meadow View Convalescent Home				West King Street ✓			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>Lillie M. Little</b>				<b>11/29/55</b> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>May 2, 1878</b>	<b>77</b>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife, Housework</b>		<b>Own home</b>		<b>Adams County, Pa.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Melchoir Slinghoff</b>				<b>Rebecca Bloom</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT'S ADDRESS			
<b>No</b>		<b>None</b>		<b>John W. Little, Littlestown, Pa.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.2 IMMEDIATE CAUSE (A) <b>Chronic myocarditis with failure</b>						<b>1 year</b>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>MAY 26, 1954</b> , to <b>NOV. 19, 1955</b> , that I last saw the deceased alive on <b>NOV. 28, 1955</b> , and that death occurred at <b>5:05 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>L. L. Potter</b>		M.D. <b>Littlestown, Pa.</b>		ADDRESS (Street, city, town, state)		DATE SIGNED <b>Nov 29, 1955</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12/1/55</b>		<b>Mt. Carmel Cemetery</b>		<b>Littlestown, Adams Co., Pa.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>12-1-55</b>		<b>H. Annist Mully</b>		<b>John W. Little</b>		<b>Littlestown, Pa.</b>	







**INSTRUCTIONS**

**1**

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VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10685

**CERTIFICATE OF DEATH**

10690

Reg. Dist. No. 24

1. PLACE OF DEATH <u>Sykesville</u>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cornell</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Sykesville</u>		LENGTH OF STAY (In this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mitchellville</u>		<u>02X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Everett</u> (First) <u>(none)</u> (Middle) <u>Loveless</u> (Last)				4. DATE OF DEATH (Month) <u>11</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>1881</u> <u>12/3/1880</u>	9. AGE last birthday <u>73</u> <u>74</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if <u>Tobacco farmer</u> )		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Richard Loveless</u>				14. MOTHER'S MAIDEN NAME <u>rebecca</u> <u>Julia A. Wells</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>unk</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT & ADDRESS <u>Hospital records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>002X</u> <u>Pulmonary Tuberculosis</u>						<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>c.B.S. due to cerebral arteriosclerosis</u>						<u>years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/3</u> , 19 <u>55</u> , to <u>11/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/13</u> , 19 <u>55</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gertrude M. Groom, M.D.</u>				DATE SIGNED <u>11/13/55</u>			
ADDRESS (Street, city, town, state) <u>Springfield State Hosp. Sykesville, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		LOCATION (City, town, or county) <u>Upper Marlboro, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>C. Harry Wier</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros.</u>		ADDRESS <u>Upper Marlboro, Md.</u>	
DATE <u>Nov. 17, 1955</u>							



10686

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>---</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>	LENGTH OF STAY (in this place) <u>since 9/9/52</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>3901-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>903 Bradford</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Joseph</u> <u>-</u> <u>LUTNER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>November 1st 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>March 27, 1867</u>
9. AGE last birthday <u>88</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>---</u> <u>---</u> <u>---</u> <u>---</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Tailor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Tailoring</u>	
11. BIRTHPLACE (State or foreign country): <u>Bohemia</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>Antony Lutner</u>		14. MOTHER'S MAIDEN NAME: <u>Katerin ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records of Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
<u>447X</u> IMMEDIATE CAUSE		<u>5 days</u>	
ANTECEDENT CAUSE (S):		<u>more than</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<u>3 yrs.</u>	
(A) <u>Bronchopneumonia</u> DUE TO			
(B) <u>Arteriosclerosis with hypertension</u> DUE TO			
(C) <u>---</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		more than	
<u>Psychosis with senile brain disease</u>		<u>3 yrs.</u>	
19A. DATE OF OPERATION: <u>---</u>	19B. MAJOR FINDINGS OF OPERATION: <u>---</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>---</u>	21C. WHERE DID INJURY OCCUR? <u>---</u>	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>---</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>---</u>	
22. I hereby certify that I attended the deceased from <u>Nov. 25, 1952</u> , to <u>Oct. 31, 1955</u> , that I last saw the deceased alive on <u>Oct. 31, 1955</u> , and that death occurred at <u>6:30AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Martin Gross, M.D.</u>		ADDRESS <u>Sykesville, Md.</u>	
DATE SIGNED <u>11/1/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Nov. 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>11/2/55</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>Fr. Cvach &amp; Son-</u>	ADDRESS <u>900 N. Chester St. 5</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONTINUATION OF THE REPORT OF THE

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10687

## CERTIFICATE OF DEATH

10692

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		since <u>4-22-54</u>		TOWN <u>Baltimore, Md</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15</u> <u>Springfield State Hospital</u>				<u>4913 Catalpha Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Henry</u>		(Middle) <u>(Maish)</u>		(Last) <u>Maisch</u>		(Date) <u>11</u> <u>5</u> <u>1955</u>	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>M</u>	<u>W</u>	<u>married</u>	<u>8 - 25 - 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>salesman</u>		<u>paints</u>		<u>Unk -</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Henry Maish</u>				<u>Mary Russell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>unk</u>		<u>unk</u>		<u>Hospital Records</u>			
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>422.1</u> IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 y +</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Chr. brain syndr. ass. with disturb. of metabolism growth or nutr. with senile br. dis. w. psych. reaction</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from <u>10-22-</u> <u>1955</u>, to <u>11-5-</u> <u>1955</u>, that I last saw the deceased alive on <u>11-4-</u> <u>1955</u>, and that death occurred at <u>9:02 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>Edmund Lusthaus</u> M.D.				<u>Sykesville, Md.</u> <u>Nov. 5, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Nov. 8, 1955</u>		<u>Woodlawn Cemetery</u>		<u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
		<u>P. Harry Miller</u>		<u>Leonard J. Ruck, 5305 Harford Road #14</u>			
<b>DATE</b>							
<u>Nov. 5, 1955</u>							







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INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10693

## 10688 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u> MARYLAND				STATE <u>Maryland</u> COUNTY _____			
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Rural - Sykesville</u>				CITY (If outside corporate limits, write RURAL end give nearest town) <u>Baltimore City</u>			
TOWN _____				TOWN _____			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2259 Reisterstown Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Arthur</u> (Middle) <u>LeGrande</u> (Last) <u>McMANN</u>				(Month) <u>November</u> (Day) <u>10</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>single</u>		<b>8. DATE OF BIRTH</b> <u>unknown</u>	
<b>9. AGE last birthday</b> <u>About 55</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months _____ Days _____		<b>11. IF UNDER 24 HRS.</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>electrician</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> _____		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Grandhaven, Michigan</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>United States</u>							
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Records of Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>491X</b> IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>				more than <u>3 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____				probably more than <u>10 yrs.</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Psychosis with cerebral arteriosclerosis</u>							
<b>19a. DATE OF OPERATION</b> _____		<b>19b. MAJOR FINDINGS OF OPERATION</b> _____		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> _____		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) _____ (County) _____ (State) _____			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____ M. _____		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> _____			
<b>22. I hereby certify that I attended the deceased from <u>June 9</u>, 19<u>52</u>, to <u>Nov. 9</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov. 9</u>, 19<u>55</u>, and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Malvin S. M. D. Martin Gross, M.D.</u>				<b>DATE SIGNED</b> <u>11/10/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Nov. 12, 1955</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>New Cathedral Cemetery</u>		<b>LOCATION (City, town, or county)</b> <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Nov. 14, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry Myers</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. J. Tiekner &amp; Sons, Inc., Baltimore, Md.</u>			

10099

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

# 10098 CERTIFICATE OF DEATH

Date of Birth

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

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VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10689

## CERTIFICATE OF DEATH

10694

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>CARROLL</b>		STATE <b>Maryland</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		LENGTH OF STAY (in this place) <b>1 mo. 10 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore-13</b>		<b>3V01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>15 Springfield State Hospital</b>		STREET ADDRESS <b>2104 East Federal Street and/or 3611 Raymonn Avenue</b>					
<b>3. NAME OF DECEASED</b> (Type or Print) <b>George G. Meckes</b>				<b>4. DATE OF DEATH</b> (Month) <b>11</b> (Day) <b>3</b> (Year) <b>19 55</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Widowed</b>	<b>8. DATE OF BIRTH</b> <b>11/12/66</b>	<b>9. AGE last birthday</b> <b>88</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>George Meckes</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Meckes Brandt</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b> <b>218-09-7984 A</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Record, Springfield State Hospital</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>Myocardial infarction</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>days</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B)</b> <b>coronary insufficiency</b>						<b>days</b>	
<b>(C)</b> <b>Hypertensive arteriosclerotic cardiovascular disease</b>						<b>years</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>Chronic brain syndrome associated with senile brain disease, with psychotic reaction</b>						<b>4 years</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 10/15, 19 55, to 11/3, 19 55, that I last saw the deceased alive on 11/2, 19 55, and that death occurred at 5:35A, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Edmund Lusthaus</b>				<b>ADDRESS (Street, city, town, state)</b> <b>Sykesville, Maryland</b>		<b>DATE SIGNED</b> <b>11/3/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>Nov 5, 1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Emmanuel</b>	
<b>24. REC'D BY REGISTRAR</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>DATE</b> <b>NOV 4 1955</b>				<b>Harry Kuer</b>		<b>John F. Seufel 5311 Edmondson Ave 29</b>	

RECEIVED  
 DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 DIVISION OF VITAL RECORDS  
 JAN 10 1955

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

Form No. 100-100

I. DECEASED PERSON'S NAME AND ADDRESS NAME: <u>JOHN J. SMITH</u> ADDRESS: <u>1234 E. BALTIMORE AVE.</u> CITY: <u>BALTIMORE, MD.</u>		II. PLACE OF DEATH PLACE: <u>HOME</u> CITY: <u>BALTIMORE, MD.</u>	
III. SEX AND AGE SEX: <u>MALE</u> AGE: <u>45</u>		IV. OCCUPATION OCCUPATION: <u>CLERK</u>	
V. DATE OF DEATH DATE: <u>JAN 5 1955</u>		VI. TIME OF DEATH TIME: <u>10:30 AM</u>	
VII. CAUSE OF DEATH CAUSE: <u>HEART DISEASE</u>		VIII. MANNER OF DEATH MANNER: <u>NATURAL</u>	
IX. SIGNATURE OF DECEASED PERSON SIGNATURE: <u>[Signature]</u>		X. SIGNATURE OF WITNESSES SIGNATURE: <u>[Signature]</u>	
XI. SIGNATURE OF PHYSICIAN SIGNATURE: <u>[Signature]</u>		XII. SIGNATURE OF CORONER SIGNATURE: <u>[Signature]</u>	

RECEIVED  
 BUREAU A. S.  
 JAN 10 1955

Reg. Dist. No. ....

## 1

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	MARYLAND  LENGTH OF STAY (In this place)	STATE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)	
X Sykesville Springfield State Hospital	5 years	Baltimore 3111 Broadway Ave	3 Vol 14 ✓
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) (Middle) (Last)		(Month) (Day) (Year)	
ANNIE Moxinger		Nov. 11 1955	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Female	White	widowed	10-25-80
		9. AGE last birthday	IF UNDER 1 YEAR IF UNDER 24 HRS.
		75 yrs.	Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
housewife		Home	Baltimore Md
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Henry Neumaister		Sarah Korns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		- - - - -	
		17. INFORMANT & ADDRESS	
		Hospital records	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
443x IMMEDIATE CAUSE (A)		Cerebral Hemorrhage	
ANTECEDENT CAUSE(S) DUE TO		Hypertensive cardiovascular disease	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Psychosis with cerebral arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
M.		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5/31, 1950, to 11/11, 1955, that I last saw the deceased alive on 11/11, 1955, and that death occurred at 12:50 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
Gerhard Sprueyfeldt, M.D. Springfield State Hospital Sykesville Md		11-11-1955	
DATE		DATE SIGNED	
Nov. 11, 1955		11-11-1955	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Zion	
DATE THEREOF		LOCATION (City, town, or county) (State)	
11-14-55		Stammers Run, Md.	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
C. Henry Zick		Ulrich Funeral Home 4210 Belvidere Rd	



# NOTIFICATION

1. This form is to be filled out by the person who has knowledge of the death and is to be submitted to the Bureau of Health Statistics, State of Maryland, as soon as possible after the death. It is to be filled out for all deaths, whether or not the death is reported to the Bureau of Health Statistics. It is to be filled out for all deaths, whether or not the death is reported to the Bureau of Health Statistics. It is to be filled out for all deaths, whether or not the death is reported to the Bureau of Health Statistics.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10000 CERTIFICATE OF DEATH

Reg. Dist. No.

2. UNUSUAL CAUSES, MANNER OF DEATH OR

3. PLACE OF DEATH

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CLERK

15. SIGNATURE OF JUDGE

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF CORONER

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF JUDGE

21. SIGNATURE OF SHERIFF

22. SIGNATURE OF CORONER

23. SIGNATURE OF JURY

24. SIGNATURE OF COURT

25. SIGNATURE OF JUDGE

26. SIGNATURE OF SHERIFF

27. SIGNATURE OF CORONER

28. SIGNATURE OF JURY

29. SIGNATURE OF COURT

30. SIGNATURE OF JUDGE

31. SIGNATURE OF SHERIFF

32. SIGNATURE OF CORONER

33. SIGNATURE OF JURY

34. SIGNATURE OF COURT

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CORONER

38. SIGNATURE OF JURY

39. SIGNATURE OF COURT

40. SIGNATURE OF JUDGE

41. SIGNATURE OF SHERIFF

42. SIGNATURE OF CORONER

43. SIGNATURE OF JURY

44. SIGNATURE OF COURT

BUREAU V. S.

ON 17 1955

RECEIVED



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10691 **CERTIFICATE OF DEATH**

10696

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL or give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>2 Mos. 10 days</u>		TOWN <u>Chevy Chase</u>		<u>15X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>4504 Walsh Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>ALBERT BROOKHART NIESS</u>				<u>11 2 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>10/4/84</u>	<u>71</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Deputy Commissioner Internal Revenue Dept.</u>					<u>Pennsylvania</u>		<u>USA</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John H. Niess</u>				<u>Sarah Bruckhart</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or ank.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>7-7-55</u>		<u>record, Springfield State Hospital</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						<u>years</u>	
STATING UNDERLYING CAUSE LAST. DUE TO							
(C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<u>6 years</u>	
<u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychosis, Parkinsonism</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>10/7</u>, 19 <u>55</u>, to <u>11/2</u>, 19 <u>55</u>, that I last saw the deceased alive on <u>11/2</u>, 19 <u>55</u>, and that death occurred at <u>11:20P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>		<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>			
<u>Edmund Luthans M.D.</u>		<u>Sykesville, Maryland</u>		<u>11/3/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>burial</u>		<u>11/5/55</u>		<u>Oak Hill</u>		<u>Washington DC</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Nov. 3, 1955</u>		<u>C. Harry Wick</u>		<u>Joseph Burch's Son</u>		<u>3034 1st NW Wash DC</u>	



## INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10692 CERTIFICATE OF DEATH

10697

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Md.</u>		COUNTY <u>                    </u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>3 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>		<u>3401/4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>3920 E. Pratt St.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Carmine</u>				<b>4. DATE OF DEATH</b> (Month) <u>Nov.</u> (Day) <u>13</u> (Year) <u>1955</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>		8. DATE OF BIRTH <u>SEPTEMBER 6 1884</u>	
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>          </u> Days <u>          </u>		11. IF UNDER 24 HRS. Hours <u>          </u> Min. <u>          </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor P. R. R. E.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>                    </u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
12. CITIZEN OF WHAT COUNTRY? <u>alien</u>							
13. FATHER'S NAME <u>NICOLA NOTTE</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ARCARA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>717-07-6302</u>		17. INFORMANT & ADDRESS <u>Records of Springfield State Hosp.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.0 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Decompensated arterioscler. heart disease more than 5 yrs</u>							
DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile brain disease</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Nov. 15, 1952, to Nov. 13, 1955, that I last saw the deceased alive on Nov. 12, 1955, and that death occurred at 6:50 AM, from the causes and on the date stated above.</b>							
SIGNATURE <u>Martin Gross, M.D.</u>				ADDRESS (Street, city, town, state) <u>Sykesville, Md.</u>		DATE SIGNED <u>Nov. 13, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 16/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cem.</u>		LOCATION (City, town, or county) (State) <u>Dundak Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Perry Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Frank Della Noce</u>		ADDRESS <u>322 S. High St.</u>	

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

# CERTIFICATE OF DEATH

Form No. 1, Rev. 1-1-35

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX ☐ MALE ☐ FEMALE

4. AGE ☐ YEARS ☐ MONTHS ☐ DAYS

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF REGISTRAR

18. SIGNATURE OF VENDOR

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

BUREAU V. S.

NOV 16 1935

RECEIVED

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1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10698

## 10693 CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Keymar</u>		<u>Life</u>		TOWN <u>Keymar</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
13. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<u>Wilbur Hinea Otto</u>				<u>11 21 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Oct 15 - 1877</u>	<u>78</u> yrs.	Months	Days	Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>R.R. Agent</u>		<u>W.M.R.R. Co</u>		<u>Carroll Co MD.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas G. Otto</u>				<u>Catherine Hinea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>705-104777</u>		<u>MARRIAN OTTO</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>						<u>2 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arteriosclerosis</u>						<u>Sym.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral Arteriosclerosis with Convulsions</u>						<u>1 year</u>	
<u>Fractured Skull</u>						<u>14 Mos.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
		<u>Home</u>		<u>Keymar Carroll Md.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
<u>Sept. 16, 1954 11 A M.</u>		<input type="checkbox"/> <input checked="" type="checkbox"/>		<u>Fell from ladder</u>			
22. I hereby certify that I attended the deceased from <u>11/27</u> , 19 <u>51</u> , to <u>11/21</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/21/55</u> , 19 <u>55</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>R. J. McVaugh</u>		<u>Toweytown, Md.</u>		<u>11/21/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>11-24-55</u>		<u>Haughis</u>		<u>Near Keymar Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>20. 23, 1955</u>		<u>Philip E. Reppe</u>		<u>Raymond K Wright</u>		<u>Union Bridge MD</u>	



30898

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

# 10033CERTIFICATE OF DEATH

Dec. 1st 1918

1. NAME - SURVIVOR (NAME OF DECEASED)

DATE

PLACE

TIME

AGE

SEX

CAUSE

PLACE

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10694

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10699  
Reg. Dist.

No. 74

<b>1. PLACE OF DEATH:</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Carroll</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)		CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Rural - Hydenville</u>	LENGTH OF STAY (in this place) <u>10 years</u>	TOWN <u>Rural - Hydenville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	

<b>3. NAME OF DECEASED:</b> (Type or Print)		(First) <u>Mary</u>	(Middle) <u>E.</u>	(Last) <u>Parker</u>	<b>4. DATE OF DEATH</b>	(Month) <u>Nov.</u>	(Day) <u>25</u>	(Year) <u>1955</u>
<b>5. SEX:</b> <u>St.</u>	<b>6. COLOR OR RACE:</b> <u>Col.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):</b> <u>Married</u>		<b>8. DATE OF BIRTH:</b> <u>10-5-1875</u>	<b>9. AGE last birthday:</b> <u>80</u> yrs.	<b>10. IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>		<b>11. IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired): <u>Homemaker</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY:</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country): <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME:</b> <u>Andrew Dorsey</u>				<b>14. MOTHER'S MAIDEN NAME:</b> <u>Gloriana Harvey</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY No.:</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS:</b> <u>Augustus Rheubottom - Hydenville, Md.</u>				

<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 years -</u>
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>		
<b>Immediate cause</b> (a) <u>Pneumonia tuberculosis</u> DUE TO <b>Antecedent cause(s)</b> (b) Diseases or conditions, if any, giving rise to the above cause <b>DUE TO</b> stating underlying cause last (c)		
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>		

<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>		<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>	<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>	<b>21c. (City or town) (County) (State)</b>		
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>	<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	<b>21f. HOW DID INJURY OCCUR?</b>		

**22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.**

**SIGNATURE** James G. Thomas **CHIEF MEDICAL EXAMINER** ☐ **DATE SIGNED** 11/25/55  
**M. D. DEPUTY MEDICAL EXAMINER** ☒ **ASSISTANT MEDICAL EXAM.**

<b>23. BURIAL, CREMATION, REMOVAL, (Specify):</b> <u>Burial</u>	<b>DATE THEREOF</b> <u>11-28-55</u>	<b>NAME OF CEMETERY OR CREMATORY</b> <u>Bushy Park</u>	<b>LOCATION (City, town, or county) (State)</b> <u>Cooksville, Howard Md.</u>
<b>DATE REC'D BY LOCAL REG.</b> <u>Nov. 27, 1955</u>	<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry Allen</u>		<b>24. FUNERAL DIRECTOR</b> <u>Arthur A. Haight - Hydenville, Md.</u>
			<b>ADDRESS</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
NOV 29 1955  
BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10695 CERTIFICATE OF DEATH

10700

Reg. Dist. No. 74

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>B</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
X TOWN <u>Rural - Sykesville</u>		7 Mos. 2 days		TOWN <u>Baltimore</u>		3Y01.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
15 <u>Springfield State Hospital</u>				<u>1705 Carswell Street</u> ✓			
3. NAME OF DECEASED (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)			
<u>JOHN</u>		<u>FRANCIS</u>		<u>11/</u>		<u>28/</u> 19 <u>55</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>2/24/69</u>	<u>86</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>contractor's work</u>		<u>unk.</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Parks</u>				<u>Sadie B. Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>215-18-3045</u>		<u>Record, Springfield State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Arteriosclerotic heart disease</u>						<u>years</u>	
(C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>2 years</u>	
<u>Chronic Brain Syndrome associated with senile brain disease with psychosis; fracture right femur</u>						<u>7 weeks</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>hospital</u>		<u>hospital</u>		<u>Sykesville Carroll Maryland</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>10</u> <u>7</u> <u>55</u> M.				<u>Patient slid from chair to floor.</u>			
22. I hereby certify that I attended the deceased from <u>10/8</u> , 19 <u>55</u> , to <u>11/28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>55</u> , and that death occurred at <u>12 Noon</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>Walter H. Sonnenfeldt M.D.</u>		<u>Sykesville, Maryland</u>		<u>11/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12-1-55</u>		<u>Parkwood</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Nov. 29, 1955</u>		<u>Anthony J. ...</u>		<u>Wm. Cook, Inc. 12124th Street H. Ball</u>			

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. EDUCATION

11. RELIGION

12. RACE

13. DATE OF BIRTH

14. TIME OF BIRTH

15. CAUSE OF DEATH

16. PLACE OF BIRTH

17. OCCUPATION

18. MARITAL STATUS

19. EDUCATION

20. RELIGION

21. RACE

22. DATE OF BIRTH

23. TIME OF BIRTH

24. CAUSE OF DEATH

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. RACE

31. DATE OF BIRTH

32. TIME OF BIRTH

33. CAUSE OF DEATH

34. PLACE OF BIRTH

35. OCCUPATION

36. MARITAL STATUS

37. EDUCATION

38. RELIGION

39. RACE

40. DATE OF BIRTH

41. TIME OF BIRTH

42. CAUSE OF DEATH

43. PLACE OF BIRTH

44. OCCUPATION

45. MARITAL STATUS

46. EDUCATION

47. RELIGION

48. RACE

49. DATE OF BIRTH

50. TIME OF BIRTH

51. CAUSE OF DEATH

52. PLACE OF BIRTH

53. OCCUPATION

54. MARITAL STATUS

55. EDUCATION

56. RELIGION

57. RACE

58. DATE OF BIRTH

59. TIME OF BIRTH

60. CAUSE OF DEATH

61. PLACE OF BIRTH

62. OCCUPATION

63. MARITAL STATUS

64. EDUCATION

65. RELIGION

66. RACE

67. DATE OF BIRTH

68. TIME OF BIRTH

69. CAUSE OF DEATH

70. PLACE OF BIRTH

71. OCCUPATION

72. MARITAL STATUS

73. EDUCATION

74. RELIGION

75. RACE

76. DATE OF BIRTH

77. TIME OF BIRTH

78. CAUSE OF DEATH

79. PLACE OF BIRTH

80. OCCUPATION

81. MARITAL STATUS

82. EDUCATION

83. RELIGION

84. RACE

85. DATE OF BIRTH

86. TIME OF BIRTH

87. CAUSE OF DEATH

88. PLACE OF BIRTH

89. OCCUPATION

90. MARITAL STATUS

91. EDUCATION

92. RELIGION

93. RACE

NOTICE

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH. IT IS TO BE KEPT IN THE OFFICE OF THE REGISTRAR OF DEATHS AND IS NOT TO BE LOANED OR REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE REGISTRAR. IT IS TO BE DESTROYED AFTER FIFTY YEARS FROM THE DATE OF DEATH.

BUREAU V. S.

NOV 30 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10696

## CERTIFICATE OF DEATH

10701

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Sykesville</u>		<u>21 Y, 2 M, 0 D</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>2707 Grindon Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Joseph Poist</u>				<u>11 9 19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>1/10/68</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Collector</u>			<u>Und.</u>	<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Joseph Poist</u>				<u>Anna Becker Taylor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS			
<u>unknown</u>			<u>4444</u>				
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>446X</u> IMMEDIATE CAUSE (A)				<u>Nephrosclerosis</u>		<u>years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Manic depressive psychosis, mixed type</u>		<u>60 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9/29</u> , 19 <u>55</u> , to <u>11/9</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/9</u> , 19 <u>55</u> , and that death occurred at <u>10:05AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walther H. Jounenfeldt</u>				M.D.		DATE SIGNED <u>11/9/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11-11-55</u>		<u>Roudon Park</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Nov. 9, 1955</u>		<u>C. Harry Allen</u>		<u>Roudon Park</u>		<u>5305 Harford Rd.</u>	

10701

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

## CERTIFICATE OF DEATH

Date of Death

1. Name of Deceased (Print or Type)

2. Sex (Male or Female)

3. Race (Print or Type)

4. Date of Birth

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BUREAU V. S.

NOV 14 1955

RECEIVED

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10697

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10702

Reg. Dist. *WC*No. *74*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Sykesville</u>		<u>4 yr. 1 mo. 15 days</u>		TOWN <u>Cedar Grove</u>		<u>158-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>WILLIS ALBERT POOLE</u>				<u>11- 14 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Separated</u>	<u>5-21-82</u>	<u>73</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Unk -</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Fillmore Poole</u>				14. MOTHER'S MAIDEN NAME: <u>Maggie --</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>Unk -</u>		17. INFORMANT & ADDRESS: <u>Hospital records</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>465X</u> Immediate cause (a) <u>Bilateral Bronchopneumonia</u> DUE TO							<u>3 days</u>
Antecedent cause(s) (b) <u>Pulmonary infarct, right lower lobe</u> Diseases or conditions, if any, giving rise to the above cause DUE TO <u>904-11</u> stating underlying cause last (c)							<u>5 days</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis, simple deterioration.</u>							<u>5 yrs. +</u>
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Hospital</u>		21c. (City or town) (County) (State)			
<u>Sykesville Carroll Maryland</u>							
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 3 55 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Patient fell. Fractured right hip.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James J. Shovel</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <u>11-15-55</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify): <u>Burial</u>		DATE THEREOF <u>Nov. 17, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Salon Methodist</u>		LOCATION (City, town, or county) (State) <u>Cedar Grove, Md</u>	
DATE REC'D BY LOCAL REG. <u>Nov. 14, 1955</u>		REGISTRAR'S SIGNATURE <u>C. Harry Miller</u>		24. FUNERAL DIRECTOR <u>John L. Mohaworth</u>		ADDRESS <u>Danvers, Md</u>	

RECEIVED

NOV 18 1955

BUREAU V. S.

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10703

10698 **CERTIFICATE OF DEATH**

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gamber</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gamber</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gamber</u>		LENGTH OF STAY (In this place) <u>life</u>		TOWN <u>Gamber</u>		TOWN <u>Gamber</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Finksburg R 1</u>		STREET ADDRESS (If rural give location) <u>Finksburg R 1</u>					
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Bessie</u> <u>none</u> <u>Raver</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Nov.</u> <u>19</u> <u>55</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 2, 1885</u>	<b>9. AGE last birthday</b> <u>70</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Carroll County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Francis B. Yingling</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anna E. Harry</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>A. J. Raver Finksburg 1, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Coronary Thrombosis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hr</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>✓</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> DUE TO (C) <u>✓</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>✓</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>✓</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input checked="" type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>✓</u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <u>✓</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) <u>✓</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>✓</u>			
<b>22. I hereby certify that I attended the deceased from <u>11-8-55</u>, to <u>11-19-55</u>, that I last saw the deceased alive on <u>11-19-55</u>, and that death occurred at <u>11:30</u> P.M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James B. Saffell</u>		<b>DATE THEREOF</b> <u>Nov. 22, 55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Westminster Cemetery</u>		<b>LOCATION (city, town, or county) (State)</b> <u>Westminster, Maryland</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>24. REC'D BY REGISTRAR</b> <u>Ham T. Miller</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John R. Byers</u>		<b>ADDRESS</b> <u>Westminster, Md.</u>	

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

REG. ONE-110

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX (Male or Female)

3. AGE (Years, months, days)

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF DECEASED

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF JURY

13. SIGNATURE OF JUDGE

14. SIGNATURE OF CLERK

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF SHERIFF

17. SIGNATURE OF SHERIFF'S DEPUTY

18. SIGNATURE OF SHERIFF'S CLERK

19. SIGNATURE OF SHERIFF'S DEPUTY CLERK

20. SIGNATURE OF SHERIFF'S CLERK DEPUTY

BUREAU V. S.

NOV 20 1955

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10699

## CERTIFICATE OF DEATH

10704

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (In this place) <u>1Y 6M 13 D</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bethesda</u>		<u>15X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>107 Wooten Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>WILLIAM</u> (First) <u>LUCIEN</u> (Middle) <u>RAWLINGS</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>21</u> (Year) <u>19 55</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Divorced</u>	<b>8. DATE OF BIRTH</b> <u>3/16/05</u>	<b>9. AGE last birthday</b> <u>50</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Truck Helper; Taxi driver</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Washington, D. C.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>William F. Rawlings</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Anne Y. Flanagan</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>unk.</u> (If Yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <u>unk.</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Record, Springfield State Hospital</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>493X</b> IMMEDIATE CAUSE (A) <u>Bilateral pulmonary artery thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Progressive 3 - 4 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bilateral suppurative pneumonia, type undetermined</u>				<u>2 weeks</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic brain syndrome associated with presenile brain disease, with psychotic reaction</u>				<u>6 years?</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <u>Hospital</u>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>Hospital</u>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b> <u>Sykesville</u>		<b>(County) (State)</b> <u>06 Carroll Md.</u>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <u>10/22/55 2:30 AM</u>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b> <u>Pt. fell to floor in toilet</u>			
<b>22. I hereby certify that I attended the deceased from <u>11/3</u>, 19<u>55</u>, to <u>11/21</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11/21</u>, 19<u>55</u>, and that death occurred at <u>11:30 AM</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Walter J. Sonnenfeldt</u>				<b>ADDRESS (Street, city, town, state)</b> <u>Sykesville, Maryland</u>		<b>DATE SIGNED</b> <u>11/21/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>11/25/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Oliver's Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Washington, D. C.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>11-22-55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry W...</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. R. ...</u>		<b>ADDRESS</b> <u>5732 ...</u>	

# 10000 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

10000

Reg. Dist. No.

1. DEATH CERTIFICATE NUMBER (PRINT OR TYPE)

2. PLACE OF DEATH

3. NAME OF DECEASED (PRINT OR TYPE)  
Last, first, middle initial, and full name at birth.

4. SEX (PRINT OR TYPE)  
Male Female

5. DATE OF BIRTH (PRINT OR TYPE)  
Month, day, year.

6. PLACE OF BIRTH (PRINT OR TYPE)  
City, county, state, and country.

7. OCCUPATION (PRINT OR TYPE)  
At time of death.

8. CAUSE OF DEATH (PRINT OR TYPE)  
Immediate cause, underlying cause, and contributing cause.

9. MANNER OF DEATH (PRINT OR TYPE)  
Natural, accident, suicide, homicide, or undetermined.

10. SIGNATURE OF PHYSICIAN (PRINT OR TYPE)  
Name and title.

11. SIGNATURE OF REGISTRAR (PRINT OR TYPE)  
Name and title.

12. SIGNATURE OF WITNESSES (PRINT OR TYPE)  
Name and address.

13. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

14. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

15. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

16. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

17. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

18. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

19. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

20. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

21. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

22. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

23. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

24. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

25. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

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Name and address.

41. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

42. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

43. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

44. SIGNATURE OF DECEASED (PRINT OR TYPE)  
Name and address.

NOTIFICATION

IF AT DEATH OR NO MANDATORY REPORTING OF DEATH TO THE HEALTH DEPARTMENT, THE DEATH CERTIFICATE MUST BE FILED WITH THE HEALTH DEPARTMENT WITHIN 10 DAYS OF THE DATE OF DEATH. IF THE DEATH CERTIFICATE IS NOT FILED WITHIN THE SPECIFIED TIME, THE DEATH WILL BE RECORDED AS A "MISSING" DEATH. THE DEATH CERTIFICATE MUST BE FILED WITH THE HEALTH DEPARTMENT WITHIN 10 DAYS OF THE DATE OF DEATH. IF THE DEATH CERTIFICATE IS NOT FILED WITHIN THE SPECIFIED TIME, THE DEATH WILL BE RECORDED AS A "MISSING" DEATH.

BUREAU V. S.

NOV 28 1995

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10700 CERTIFICATE OF DEATH

10705

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sykesville</u>		<u>4 month 5 days</u>		TOWN <u>Westminster</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>15 Springfield State Hospital</u>				<u>R. F. D. #4</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>ARTHUR</u> (Middle) <u>CARROLL</u> (Last) <u>REESE</u>				(Month) <u>11</u> (Day) <u>6</u> (Year) <u>19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>10. IF UNDER 1 YEAR</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>3-3-97</u>		<u>58</u> yrs.	Months	Days
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Salesman</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Arthur Peter Reese</u>				<u>Mary Amanda Lowe</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>214-01-0481</u>		<u>Hospital records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>177X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>Suppurative Nephritis</u>						<u>3 days</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>							
<b>(B)</b>						<u>3 days +</u>	
<u>Obstruction of Ureters by stones</u>							
<b>(C)</b>							
<u>of Prostate with metastases to bones</u>						<u>3 yrs. +</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<u>Chronic brain syndrome associated with new growth, with psychotic reaction.</u>						<u>4 months +</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>7-1</u>, 19<u>55</u>, to <u>11-6</u>, 19<u>55</u>, that I last saw the deceased alive on <u>11-6</u>, 19<u>55</u>, and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<u>Walter H. Sommerfeldt</u>				<u>M.D. Springfield State Hospital - Sykesville 11/6</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>11-9-55</u>		<u>Leisters Cemetery</u>		<u>Westminster, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Nov. 8, 1955</u>		<u>C. Harry Zuer</u>		<u>Bankard 2, Westminster, Md.</u>			



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11805

## 10701 CERTIFICATE OF DEATH

Reg. Dist. No. 77

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY <u>Carroll</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
TOWN <u>Hampstead</u>		LENGTH OF STAY (In this place) <u>Life</u>		OR TOWN <u>Hampstead</u>		OR TOWN <u>Hampstead</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Upper Beecheyville Rd</u>		STREET ADDRESS (If rural give location) <u>Upper Beecheyville Rd</u>					
<b>3. NAME OF DECEASED</b> (Type or Print) <u>David Edgar</u> (First) <u>Edgar</u> (Middle) <u>Pill</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>November</u> (Day) <u>30</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>March 26 1888</u>	<b>9. AGE last birthday</b> <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	<b>IF UNDER 24 HRS.</b> Hours <u></u> Min. <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Agriculture</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Daniel W. Pill</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ellen Zepp</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>No</u>		<b>17. INFORMANT'S ADDRESS</b> <u>Mrs. Hazel Pill; 111 Hampstead Rd</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Cranial Aneurysm, Rupture</u>				<u>Cranial Heart Disease</u>		<u>sudden</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<u>Chronic Myocarditis</u>		<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <u>Chronic Myocarditis</u>				<u></u>		<u>!</u>	
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u></u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u></u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u></u>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) <u></u> (County) <u></u> (State) <u></u>			
<b>21d. TIME OF INJURY</b> (Month) <u></u> (Day) <u></u> (Year) <u></u> (Hour) <u></u>		<b>21a. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b> <u></u>			
<b>22. I hereby certify that I attended the deceased from <u>July 20</u>, 19<u>55</u>, to <u>Nov 30</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov 25</u>, 19<u>55</u>, and that death occurred at <u>9 P</u>.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph E. Bush</u> M.D. <u>Hampstead Md</u>				<b>DATE SIGNED</b> <u>Nov 30, 1955</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-3-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hampstead</u>		<b>LOCATION (City, town, or county)</b> <u>Carroll Co Md</u> (State) <u></u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Henry W. Edgar</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Edw. E. Dutton</u>		<b>ADDRESS</b> <u>Hampstead Md</u>	
<b>DATE</b> <u>12/1/55</u>							

1900 CERTIFICATE OF DEATH

Birth Date

2. DEATH RECORDING INFORMATION

1. NAME OF DECEASED <i>John Doe</i>		3. SEX <i>Male</i>		5. AGE <i>45</i>	
4. DATE OF DEATH <i>Dec 10 1955</i>		6. PLACE OF DEATH <i>Home</i>		7. CAUSE OF DEATH <i>Heart Disease</i>	
8. SIGNATURE OF DECEASED <i>John Doe</i>		9. SIGNATURE OF WITNESS <i>John Doe</i>		10. SIGNATURE OF DECEASED <i>John Doe</i>	
11. SIGNATURE OF DECEASED <i>John Doe</i>		12. SIGNATURE OF DECEASED <i>John Doe</i>		13. SIGNATURE OF DECEASED <i>John Doe</i>	
14. SIGNATURE OF DECEASED <i>John Doe</i>		15. SIGNATURE OF DECEASED <i>John Doe</i>		16. SIGNATURE OF DECEASED <i>John Doe</i>	
17. SIGNATURE OF DECEASED <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>		19. SIGNATURE OF DECEASED <i>John Doe</i>	
20. SIGNATURE OF DECEASED <i>John Doe</i>		21. SIGNATURE OF DECEASED <i>John Doe</i>		22. SIGNATURE OF DECEASED <i>John Doe</i>	
23. SIGNATURE OF DECEASED <i>John Doe</i>		24. SIGNATURE OF DECEASED <i>John Doe</i>		25. SIGNATURE OF DECEASED <i>John Doe</i>	
26. SIGNATURE OF DECEASED <i>John Doe</i>		27. SIGNATURE OF DECEASED <i>John Doe</i>		28. SIGNATURE OF DECEASED <i>John Doe</i>	
29. SIGNATURE OF DECEASED <i>John Doe</i>		30. SIGNATURE OF DECEASED <i>John Doe</i>		31. SIGNATURE OF DECEASED <i>John Doe</i>	
32. SIGNATURE OF DECEASED <i>John Doe</i>		33. SIGNATURE OF DECEASED <i>John Doe</i>		34. SIGNATURE OF DECEASED <i>John Doe</i>	
35. SIGNATURE OF DECEASED <i>John Doe</i>		36. SIGNATURE OF DECEASED <i>John Doe</i>		37. SIGNATURE OF DECEASED <i>John Doe</i>	
38. SIGNATURE OF DECEASED <i>John Doe</i>		39. SIGNATURE OF DECEASED <i>John Doe</i>		40. SIGNATURE OF DECEASED <i>John Doe</i>	
41. SIGNATURE OF DECEASED <i>John Doe</i>		42. SIGNATURE OF DECEASED <i>John Doe</i>		43. SIGNATURE OF DECEASED <i>John Doe</i>	
44. SIGNATURE OF DECEASED <i>John Doe</i>		45. SIGNATURE OF DECEASED <i>John Doe</i>		46. SIGNATURE OF DECEASED <i>John Doe</i>	
47. SIGNATURE OF DECEASED <i>John Doe</i>		48. SIGNATURE OF DECEASED <i>John Doe</i>		49. SIGNATURE OF DECEASED <i>John Doe</i>	
50. SIGNATURE OF DECEASED <i>John Doe</i>		51. SIGNATURE OF DECEASED <i>John Doe</i>		52. SIGNATURE OF DECEASED <i>John Doe</i>	
53. SIGNATURE OF DECEASED <i>John Doe</i>		54. SIGNATURE OF DECEASED <i>John Doe</i>		55. SIGNATURE OF DECEASED <i>John Doe</i>	
56. SIGNATURE OF DECEASED <i>John Doe</i>		57. SIGNATURE OF DECEASED <i>John Doe</i>		58. SIGNATURE OF DECEASED <i>John Doe</i>	
59. SIGNATURE OF DECEASED <i>John Doe</i>		60. SIGNATURE OF DECEASED <i>John Doe</i>		61. SIGNATURE OF DECEASED <i>John Doe</i>	
62. SIGNATURE OF DECEASED <i>John Doe</i>		63. SIGNATURE OF DECEASED <i>John Doe</i>		64. SIGNATURE OF DECEASED <i>John Doe</i>	
65. SIGNATURE OF DECEASED <i>John Doe</i>		66. SIGNATURE OF DECEASED <i>John Doe</i>		67. SIGNATURE OF DECEASED <i>John Doe</i>	
68. SIGNATURE OF DECEASED <i>John Doe</i>		69. SIGNATURE OF DECEASED <i>John Doe</i>		70. SIGNATURE OF DECEASED <i>John Doe</i>	
71. SIGNATURE OF DECEASED <i>John Doe</i>		72. SIGNATURE OF DECEASED <i>John Doe</i>		73. SIGNATURE OF DECEASED <i>John Doe</i>	
74. SIGNATURE OF DECEASED <i>John Doe</i>		75. SIGNATURE OF DECEASED <i>John Doe</i>		76. SIGNATURE OF DECEASED <i>John Doe</i>	
77. SIGNATURE OF DECEASED <i>John Doe</i>		78. SIGNATURE OF DECEASED <i>John Doe</i>		79. SIGNATURE OF DECEASED <i>John Doe</i>	
80. SIGNATURE OF DECEASED <i>John Doe</i>		81. SIGNATURE OF DECEASED <i>John Doe</i>		82. SIGNATURE OF DECEASED <i>John Doe</i>	
83. SIGNATURE OF DECEASED <i>John Doe</i>		84. SIGNATURE OF DECEASED <i>John Doe</i>		85. SIGNATURE OF DECEASED <i>John Doe</i>	
86. SIGNATURE OF DECEASED <i>John Doe</i>		87. SIGNATURE OF DECEASED <i>John Doe</i>		88. SIGNATURE OF DECEASED <i>John Doe</i>	
89. SIGNATURE OF DECEASED <i>John Doe</i>		90. SIGNATURE OF DECEASED <i>John Doe</i>		91. SIGNATURE OF DECEASED <i>John Doe</i>	
92. SIGNATURE OF DECEASED <i>John Doe</i>		93. SIGNATURE OF DECEASED <i>John Doe</i>		94. SIGNATURE OF DECEASED <i>John Doe</i>	
95. SIGNATURE OF DECEASED <i>John Doe</i>		96. SIGNATURE OF DECEASED <i>John Doe</i>		97. SIGNATURE OF DECEASED <i>John Doe</i>	
98. SIGNATURE OF DECEASED <i>John Doe</i>		99. SIGNATURE OF DECEASED <i>John Doe</i>		100. SIGNATURE OF DECEASED <i>John Doe</i>	

BUREAU V. 3

DEC 12 1955

RECEIVED

EXHIBIT

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10706

10702 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Carroll</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>	LENGTH OF STAY (in this place) <u>6 mo 2/day</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	<u>3V01-4</u>
TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>		STREET ADDRESS (If rural give location) <u>117 S. Ann Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Wladyslaw Senders (Last) (First) (Middle) Loretta Sanders</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>11 24 1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>? 2 1897</u>
9. AGE last birthday <u>58</u> yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
13. FATHER'S NAME <u>WINCENTY KALICINSKI</u>		14. MOTHER'S MAIDEN NAME <u>GRABOSZ</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS <u>Mr. STANISLAUS SENDERS 117 S. Ann St</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		15. MEDICAL CERTIFICATION	
289.0 IMMEDIATE CAUSE (A) <u>Pick's disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 mo +</u>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Presenile dementia: Pick's disease</u>		10 mo +	
19a. DATE OF OPERATION <u>11-12-55</u>		19b. MAJOR FINDINGS OF OPERATION <u>Ash-encephalogram: Pick's disease</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (M. et work <input type="checkbox"/> Not while et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>11-11-1955</u> to <u>11-24-1955</u> , that I last saw the deceased alive on <u>11-23-1955</u> , and that death occurred at <u>3:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Walther H. Sommerfeldt</u> M.D.		DATE SIGNED <u>11/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>C. Harvey Kears</u>	
DATE <u>NOV 25 1955</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Weber</u> ADDRESS <u>401 S. Chester</u>	



RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 10703

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 10707  
 Reg. Dist.

No. 74

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Carroll</b>		MARYLAND		STATE <b>Maryland</b> COUNTY <b>Montgomery</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
X TOWN <b>Rural - Sykesville</b>		<b>6 Mos. 20 days</b>		TOWN <b>Silver Spring, C</b>		<b>1556-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<b>15 Springfield State Hospital</b>				<b>3408 Glorus Place</b>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<b>Mary Ellen Schade</b>				<b>11 9 55</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>F</b>	<b>White</b>	<b>Widowed</b>	<b>2/13/83</b>	<b>72</b> yrs.	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>		<b>Home</b>		<b>Washington, D. C.</b>		<b>USA</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Patrick Hurley</b>				<b>Catherine McCarty</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<b>no</b>		<b>unk</b>		<b>Record, Springfield State Hospital</b>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <b>Pulmonary Embolism</b> DUE TO						<b>3 days</b>	
Antecedent cause(s) (b) <b>Arteriosclerotic Heart Disease</b> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <b>Fracture, right femur</b>						<b>Years</b>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Chronic Brain Syndrome associated with Circulatory Disturbance, cerebral arteriosclerosis,</b>						<b>6 years</b>	
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		<b>With psychotic reaction</b>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <b>hospital</b>		21c. (City or town) (County) (State)			
		<b>Sykesville Carroll Maryland</b>					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>11 3 55 3:30 PM</b>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>Patient either was pushed or fell to floor</b>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED <b>11/9/55</b>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>11-12-55</b>		<b>Mt. Olivet</b>		<b>WASH D. C.</b>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>Nov. 10, 1955</b>		<b>C. Harry Allen</b>		<b>Timothy H. H. H.</b>		<b>3831-29 Ave NW. Wash. D.C.</b>	

RECEIVED

NOV 14 1955

BUREAU V. 3

10708

MARYLAND

STATE DEPARTMENT OF HEALTH

## 10704 CERTIFICATE OF DEATH

Reg. Dist. No. 70

1. PLACE OF DEATH- COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Carroll</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Town Taneytown</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Town Taneytown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>12 Middle Street</b>		STREET ADDRESS <b>12 Middle Street</b>	
3. NAME OF DECEASED (Type or Print) <b>Helen Elizabeth</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>11/13/55</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>		8. DATE OF BIRTH <b>9/22/1895</b>	
9. AGE last birthday <b>60</b> yrs.		10. If under 1 year Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework, Housewife</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>William Wisotzkey</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Staley</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT AND ADDRESS (Francis E. Shaum) <b>Francis E. Shaum, Taneytown, Md.</b>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause		(a) <b>Acute Coronary Artery Occlusion</b>	<b>2 hrs.</b>
Antecedent cause(s)		(b) <b>Arteriosclerotic Heart Disease</b>	<b>5 yrs.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <b>Hypertension, Vascular</b>	<b>5 yrs.</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Dec. 5, 1950** to **Nov. 13, 1955**, that I last saw the deceased alive on **11/13/55**, and that death occurred at **10:10 p.m.**, from the causes and on the date stated above.

SIGNATURE **R. D. McVaugh M.D.** ADDRESS **Taneytown, Md.** DATE SIGNED **11/14/55**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE <b>11/16/55</b>	NAME OF CEMETERY OR CREMATORY <b>St. Josephs Cemetery</b>	LOCATION (City, town, or county) (State) <b>Taneytown, Carroll Co., Md.</b>
DATE REC'D BY LOCAL REG. <b>Nov. 14, 1955</b>	REGISTRAR'S SIGNATURE <b>Ethel M. Mahring</b>	24. FUNERAL DIRECTOR <b>A. M. Little</b>	ADDRESS <b>Littlestown, Pa.</b>

MARGIN RESERVED FOR BINDING

RECEIVED

NOV 16 1955

BUREAU V. B.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 10705 CERTIFICATE OF DEATH

10709

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		STATE <u>Maryland</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>Rural - Sykesville</u>		LENGTH OF STAY (in this place) <u>4 mos., 26 days</u>		CITY OR TOWN <u>Baltimore</u>		<u>3v01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>6500 Cedonia Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>GEORGE WILLIAM SUMPSTER</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11 9 55</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>5/17/94</u>	<b>9. AGE last birthday</b> <u>61</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>George William Sumpster</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Ida Ann Smith</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Record, Springfield State Hospital</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>1. IMMEDIATE CAUSE</b> (A) <u>Multiple Lung abscesses</u>						<u>3 days</u>	
<b>2. ANTECEDENT CAUSE(S) DUE TO</b> (B) <u>Aspiration</u>						<u>3 days</u>	
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <u>Liver cirrhosis plus diabetes mellitus</u>						<u>years</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction</u>						<u>2 - 3 years</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6/17/55</u> , <b>19</b> <u>55</u> , <b>to</b> <u>11/9</u> , <b>19</b> <u>55</u> , <b>that I last saw the deceased alive on</b> <u>11/9</u> , <b>19</b> <u>55</u> , <b>and that death occurred at</b> <u>8:35 A.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Walter H. Soumeffeldt</u> M.D.				<b>DATE SIGNED</b> <u>11/9/55</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>11-12-1955</u>		<b>NAME OF CEMETERY OR CREMATORY.</b> <u>LODON PK</u>		<b>LOCATION (City, town, or county) (State)</b> <u>BALTO. MD.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>Nov. 15, 1955</u>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry Lee</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Elmer H. Coulter</u>		<b>ADDRESS</b> <u>5444 BELAIR RD</u>	

# DECLARATION

1. I am a resident of the State of Maryland, and I am the legal next of kin of the deceased.

2. I hereby declare that the deceased died a natural death, and I am not aware of any circumstances which might lead to a suspicion of foul play.

3. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

4. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

5. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

6. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

7. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

8. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

9. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

10. I have no knowledge of any person who might be interested in the estate of the deceased, other than the persons named in this declaration.

## CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

10-1-1955

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECLARANT

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF MINISTER

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF CHURCH

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF BURIAL PLACE

17. SIGNATURE OF INTERMENT

18. SIGNATURE OF RECORDS

19. SIGNATURE OF VITALS

20. SIGNATURE OF DEATH

21. SIGNATURE OF BIRTH

22. SIGNATURE OF MARRIAGE

23. SIGNATURE OF DIVORCE

24. SIGNATURE OF WILLS

25. SIGNATURE OF ESTATES

26. SIGNATURE OF PROBATE

27. SIGNATURE OF ADULTS

28. SIGNATURE OF MINORS

29. SIGNATURE OF GUARDIAN

30. SIGNATURE OF CURATOR

31. SIGNATURE OF ADMINISTRATOR

32. SIGNATURE OF EXECUTOR

33. SIGNATURE OF LEGAL

34. SIGNATURE OF COURT

35. SIGNATURE OF JUDICIAL

36. SIGNATURE OF RECORDS

BUREAU V. S.

NOV 16 1955

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10706 CERTIFICATE OF DEATH

Reg. Dist. No. 10710

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Manchester</u>		LENGTH OF STAY (in this place) <u>5 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Manchester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Tracey Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>Tracey Mill Rd</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Robert Kinsey Turnbough</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>11-70</u> <u>1955</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>5-8-1881</u>	9. AGE last birthday <u>74</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>County Rd</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Robert K. Turnbough</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Sullivan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS: <u>Mrs. Alan Trapp, Manchester, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>450.0</u> <u>Arterio-sclerosis, small</u>						<u>10 yrs</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>01/1957</u>		19B. MAJOR FINDINGS OF OPERATION: <u>amputation of l. leg due to Arterio-sclerosis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>Nov</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11-20</u> , 19 <u>55</u> , and that death occurred at <u>5:30 p</u> M, from the causes and on the date stated above.							
SIGNATURE <u>M. D. [Signature]</u>		ADDRESS <u>[Address]</u>		DATE SIGNED <u>[Date]</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-23-55</u>		NAME OF CEMETERY OR CREMATORY <u>Sparks Methodist</u>		LOCATION (City, town, or county) (State) <u>Sparks, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/23/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Sparks, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 29 1965

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10707

## CERTIFICATE OF DEATH

10711

Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CARROLL</u>		STATE <u>MD.</u> COUNTY <u>CARROLL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BURIAL WESTMINSTER</u>		TOWN <u>BURIAL WESTMINSTER</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		LENGTH OF STAY (in this place) <u>75 yrs.</u>		STREET ADDRESS <u>P.O. 2</u>		(If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.O. 2</u>							
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>JERSEY N. UTZ</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>11-20-1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JAN. 21-1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARM LABORER AGRICULTURE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE A. UTZ</u>				14. MOTHER'S MAIDEN NAME <u>SAVILLA SNIDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>THOMAS E. UTZ WESTMINSTER MD.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular Renal disease</u>						<u>Several yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension &amp; Myocardial Degeneration</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION <u>0</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 19 55</u> , to <u>Nov 20 55</u> , that I last saw the deceased alive on <u>Nov 21 55</u> , and that death occurred at <u>6:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Speicher</u> M.D.				ADDRESS (Street, city, town, state) <u>Westminster Md</u> DATE SIGNED <u>Nov 21-1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>11-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>BACHMANS VALLEY CEM.</u>		LOCATION (City, town, or county) (State) <u>WESTMINSTER MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Harold Miller</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. B. Blandford</u>		ADDRESS <u>1801 Westminister, Md.</u>	
DATE <u>11-23-55</u>							

ENCLOSURE

RECEIVED  
NOV 26 1934  
BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

State Dist. 100

LOCAL REGISTRAR (NAME AND ADDRESS)

DATE OF DEATH

NAME

AGE

SEX

PLACE OF BIRTH

CAUSE

DATE OF DEATH

PLACE OF DEATH

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10712

## 10708 CERTIFICATE OF DEATH

Reg. Dist. No. 24

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>---</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Rural - Sykesville</u>		<u>since 7/28/50</u>		TOWN <u>Baltimore City</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springfield State Hospital</u>				STREET ADDRESS (If rural give location) <u>516 N. Curley Street #5</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Woodrow Paul - WALSON</u>				<u>Nov. 2 1955</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>male</u>	<u>white</u>	<u>single</u>	<u>May 11, 1907</u>	<u>48</u> yrs.	Months <u>---</u>	Days <u>---</u>	Hours <u>---</u> Min. <u>---</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Painter</u>		<u>Painting</u>		<u>New Jersey</u>		<u>United States</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>James Walson</u>				<u>Anna Dejoy</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>no</u>		<u>unknown</u>		<u>Records of Springfield State Hospital</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>491X IMMEDIATE CAUSE (A)</b> <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Hemiplegia</u>						<u>more than 5 years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Psychosis with cerebral arteriosclerosis</u>						<u>more than 5 years</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<u>---</u>		<u>---</u>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<input type="checkbox"/>		<u>---</u>		<u>---</u>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<u>---</u>		<u>---</u>		<u>---</u>			
<b>22. I hereby certify that I attended the deceased from <u>Nov. 30</u>, 19<u>50</u>, to <u>Nov. 1st</u>, 19<u>55</u>, that I last saw the deceased alive on <u>Nov. 1st</u>, 19<u>55</u>, and that death occurred at <u>3:10P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<u>Martin Gross, M.D.</u>				<u>Sykesville, Maryland</u>		<u>11/2/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>11-5-55</u>		<u>Mowland Park</u>		<u>Baltimore Co., Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Nov. 3, 1955</u>		<u>C. Harry Baker</u>		<u>Wm. Cook, Inc.</u>		<u>1217 1/2 Paul St. Balt.</u>	



10015

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

## CERTIFICATE OF DEATH

Reg. Form No.

1. PLACE OF DEATH

2. SEX

3. AGE

4. DATE OF BIRTH

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. RACE

15. COLOR

16. HEIGHT

17. WEIGHT

18. BUILD

19. COMPLEXION

20. HAIR

21. EYES

22. MOUTH

23. NOSE

24. EARS

25. TEETH

26. SKIN

27. FINGERPRINTS

28. SIGNATURE

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BUREAU V. 1

1955

RECEIVED

ENCLOSURE

OFFICE OF THE ATTORNEY GENERAL  
BALTIMORE, MARYLAND



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10713

## 10709 CERTIFICATE OF DEATH

Reg. Dist. No. 74

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u> City <u>311</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>40 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 14</u>		<u>03X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>15 Springfield State Hospital</u>				STREET ADDRESS <u>1808 Wendover Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Gertrude</u> (First) <u>Wockenfuss</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) <u>11</u> (Day) <u>29</u> (Year) <u>1955</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March 10, 1892</u>	<b>9. AGE last birthday</b> <u>63 years</u>	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>George Miller</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Louise Hembold</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>2726</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Sedall Moore (daughter)</u> <u>6307 Eastern Parkway Baltimore 14, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cerebral vascular accident (Hemorrhage)</u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive arteriosclerosis cardio-vasc disease</u>				<u>years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</u>				<u>years</u>			
<b>19a. DATE OF OPERATION</b> <u>0</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>10-19-1955</u> , to <u>11-29-1955</u> , that I last saw the deceased alive on <u>11-29-1955</u> , and that death occurred at <u>7:25 P.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Walther H. Sonnenfeldt</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Springfield State Hospital.</u>		<b>DATE SIGNED</b> <u>11-29-55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>12-2-55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>C. Harry Allen</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>T. J. Luck</u>		<b>ADDRESS</b> <u>5305 Bayview</u>	
<b>DATE</b> <u>Nov. 30, 1955</u>							

# 1908 CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]		MARITAL STATUS [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		MEDICAL ATTENDANT [Illegible]	
BURIAL PLACE [Illegible]		DATE OF BURIAL [Illegible]		NAME OF FUNERAL HOME [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESSES [Illegible]		SIGNATURE OF MEDICAL ATTENDANT [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		OFFICE OF REGISTRAR [Illegible]		DATE OF REGISTRATION [Illegible]	

**RECEIVED**  
 DEC 2 1955  
 BUREAU V. S.

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the jurisdiction in which the death occurred.

10714

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## 10710 CERTIFICATE OF DEATH

Reg. Dist. No. 75

1. PLACE OF DEATH: COUNTY <i>Carroll</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>MD</i> COUNTY <i>Carroll</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Manchester #1</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Manchester</i>	
TOWN <i>Manchester #1</i>		TOWN <i>Manchester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Manchester hgt #1</i>		STREET ADDRESS (If rural, give location) <i>R.R. #1</i>	
3. NAME OF DECEASED (Type or Print) <i>Sarah E. Youngling</i>		4. DATE OF DEATH (Month) <i>Nov</i> (Day) <i>19</i> (Year) <i>1955</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>4/1/1877</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>	9. AGE last birthday <i>78</i> yrs. If under 1 year Months Days Hours Min.
13. FATHER'S NAME <i>John J. Youngling</i>		12. CITIZEN OF WHAT COUNTRY <i>USA</i>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Ross E. Weaver Manchester hgt #1</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Stiles</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
<p>442X Immediate cause (a) <i>Arterio sclerotic C-V-R Disease</i></p> <p>Antecedent cause(s) (b) <i>giving rise to the above cause stating the underlying cause last</i></p> <p>(c)</p>			<i>104 d.</i>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>July 1945</i> , 19 <i>55</i> , to <i>11-19</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>11-19</i> , 19 <i>55</i> , and that death occurred at <i>4:20 P</i> m., from the causes and on the date stated above.			
SIGNATURE <i>M. Porterfield M.D.</i>		ADDRESS <i>Lanham Park</i> DATE SIGNED <i>11-21-55</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>11-22-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Baughmans Valley</i>		LOCATION (City, town, or county) <i>Manchester hgt #1</i> (State) <i>MD</i>	
DATE REC'D BY LOCAL REG. <i>Nov. 21-55</i>		REGISTRAR'S SIGNATURE <i>Mrs. W. L. Denner</i>	
		24. FUNERAL DIRECTOR <i>Frederick Becker</i> ADDRESS <i>Danvers Pa.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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NOV 28 1955

BUREAU V. S.